Blue Cross and Blue Shield of North Carolina (Blue Cross NC)
Frequently Asked Questions from Providers

Below are answers to the most frequently asked questions from providers. Please see below, review the slide decks from our webinars and read the information posted on our coronavirus provider site. These resources should answer most, if not all, of the questions we have received.

Contents

General

Are these measures for all insurance or just Blue Cross NC?

Unless otherwise noted, the following information applies to plans administered by Blue Cross and Blue Shield of North Carolina, including all Medicare Advantage plans offered or administered by Blue Cross NC, including Experience Health.

FEP recently sent out updated policies. What are they and how to they apply to what you're doing?

Our update to telehealth includes details on Federal Employee Program members. Because the situation is changing so rapidly, you should also visit the FEP website for the latest guidance and details for this segment: https://www.fepblue.org/coronavirus

Will Blue Cross NC reimburse for in-home visits during this time? If so, are there any provider types they will not consider eligible to provide in-home visits?

Yes. The use of this would depend on the contract of the provider.

When you say you will re-evaluate in 30 days, do you mean business days or consecutive days?

We will re-evaluate these measures on April 6, 2020.

You said you would reevaluate all these measures after 30 days. Have you done that?

Our COVID-19 measures are in effect as of March 6, 2020. They were extended for an additional 30-day period starting on April 5, 2020, and will be reevaluated for further extension.

Do we collect co-pays if the visit or treatment is not related directly to COVID-19?

Yes, cost-sharing is only waived for COVID-19-related testing, screening and treatment.

Why is COVID-19 coverage different for patients who see NC providers but are enrolled on an out of state Blue Cross Plan?

Inter-Plan Programs (IPP) enable members traveling or living in another plan's service area to receive their home benefits while away. A patient you're treating may physically be in North Carolina, but they may have a Blue Cross and Blue Shield plan that is not Blue Cross NC. These patients would be considered an IPP member to us because they're not Blue Cross NC members. This is why you might see differences in reimbursement or claim submission guidelines. We cannot control or guarantee any benefits or payments for IPP plans, similar to how we cannot control or guarantee benefits or payments for FEP members. You should ask the member to check the back of their insurance card and provide you

with the contact information listed for benefit verification. You also can visit the Blue Cross and Blue Shield Association's Coronavirus Updates page to find out how local Blue Cross and Blue Shield companies are responding to the pandemic.

Are there statistics on how many people in North Carolina have tested positive for COVID-19?

The North Carolina Department of Health and Human Services (NCDHHS) posts updated statistics to its COVID-19 North Carolina Dashboard online.

How do we verify a patient's benefits? Is there a COVID-19 hotline?

Check the back of the patient's ID card for contact information on benefit verification. If the patient is a a Blue Cross NC member, the customer service number listed on the back of the ID card is the contact you should use for benefit verification; we do not have a special hotline for COVID-19 benefits. You also can tell patients to visit www.bluecrossnc.com/coronavirus to see all the member policy and benefit changes we've made to support them during the pandemic. Providers can visit www.bluecrossnc.com/coronavirus-providers. As a reminder, ***we cannot guarantee coverage or reimbursement for plans that are not offered or administered by Blue Cross NC***. Coverage varies for local Blue Cross and Blue Shield plans across the nation. Please be sure to call the number of the back of the patient's ID card to verify benefits.

Telehealth

Are all specialties included in the telehealth expansion?

All specialties are included. Any contracted provider that typically sees patients in person for services which can be provided virtually through telehealth is allowed per our Reimbursement Policy.

What level/type of providers are included in the telehealth expansion?

Any contracted provider that typically sees patients in person for services which can be provided virtually through telehealth is allowed per our Reimbursement Policy. Review this page for a list of providers who are required to be credentialed.

At a high level, PharmDs are recognized as providers. Non-credentialed providers providing services under a contracted provider can bill under that contracted provider. Much like today, residents cannot bill independently today for services. If they provide telehealth services, they should be provided under a supervising / attending contracted provider.

My EOP (explanation of payment) was posted for a telehealth claim, and I still am not being paid at parity. What do I do?

We apologize. There were some claims that were processed before our systems were updated. We have identified those claims and are reprocessing them automatically. You should be receiving a check for the difference within the next 30 days.

I called your Customer Service line and was told you aren't covering telehealth for one of my patients. However, you told us in other communications that you would cover it. Why am I getting conflicting information?

We have researched this issue as we've received this feedback a number of times. We are finding that in most cases, the patient is not a Blue Cross NC member but instead belongs to another Blue Cross plan, known as an Inter-Plan Program Host member. ***We cannot guarantee coverage or reimbursement for plans that are not offered or administered by Blue Cross NC***. Coverage varies for local Blue Cross and Blue Shield plans across the nation. Please be sure to call the number of the back of the patient's ID card to verify benefits.

If you are certain the patient is a Blue Cross NC member but are still being told by Customer Service that telehealth is not covered, please ask to speak to a supervisor.

Will you require patients to come in post-pandemic for the exam portion of the visit that originally was done via telehealth?

The provider can choose to follow-up with a physical exam for the member if they feel it is necessary; however, this will not be required by Blue Cross NC.

How do I code for telehealth? Is there a difference in how we code for secure video vs. audio only?

Use face-to-face CPT or HCPCS codes plus Place of Service (02). Use the CR modifier if it's an audio-only encounter. Blue Cross NC Medicare Advantage providers should follow CMS guidance. Get more details, including specific clinical scenarios on our coronavirus provider webpage.

CMS released guidance on telehealth coding for Medicare – Are we supposed to follow that? Are you set up to accept the codes they stated that they will now cover?

Yes, all Blue Cross NC Medicare Advantage (MA) providers should follow CMS guidance and use Place of Service (POS) 11, 22 or 19 (whichever is appropriate) and the -95 modifier for telehealth. If you are a MA provider and use POS 02, the reimbursement will not be paid at parity but instead at the facility reimbursement rate. This applies to services provided to members of Blue Cross NC MA plans and the MA plan that Blue Cross NC administers for Experience Health.

Additionally, CMS released additional codes that previously were not covered but they now will approve for telehealth due to COVID-19. For a list of codes, please visit the CMS website. We are set up to accept these newly approved codes identified by CMS for telehealth for the Medicare Advantage plans that we offer/administer.

These changes are effective March 1, 2020 and will be in effect through the end of the declaration CMS implemented. If you are a Blue Cross NC MA provider and feel your telehealth claim has been paid incorrectly, please contact Medicare Advantage Provider Services at 888-296-9790.

When you provide guidance regarding Blue Cross NC Medicare, does this include Experience Health Medicare?

Yes, it includes Experience Health unless we indicate otherwise.

You mentioned that Medicare Advantage plans administered by Blue Cross NC cover audio-only telehealth visits. What about traditional Medicare?

Because the situation is evolving so rapidly, we recommend providers visit the CMS website for guidance specific to traditional Medicare.

Is coding different from provider to provider?

Follow the same guidance above. You also can get more details, including specific clinical scenarios on our coronavirus provider webpage.

If a patient has a telehealth visit and then needs to come into the office for labs, can the office bill both the telehealth visit and the labs on separate claims?

Yes, they would be on separate claims. The telehealth visit would be POS 02. The claim for the labs would be based on the place of service, either 81 or 11.

Because of restrictions on visitors in health care facilities, oftentimes we need to speak with a patient's guardian separately from the patient. How do we bill if we spoke on the phone with a patient's guardian and then followed up separately with the patient and facility nurse via telehealth (audio and/or video)? Can we include the time spent on the phone with the patient's guardian? If so, how do we code for each part of this visit?

This would follow similar scenarios when a patient is incapacitated and how you would incorporate the communication with the family or guardian. If there are separate codes that are payable, they would apply through our existing payment policies. If they're inclusive to other hospital management codes, then it would still be considered inclusive in those facility professional management codes. Hospital care evaluation and management (EM) codes designate hospital care unit/floor time (which in these scenarios could be interpreted as virtual time), and this time calculation includes communication with the patient's family. See EM services guidelines regarding time based billing in 2020 CPT®.

The Blue Book and provider contracts exclude revenue code 780 (telemedicine). Is 780 required to be present on UB claims for telemedicine services? Can or should charges be billed on the line with Revenue Code 780 (if required or optional), or should it be a zero-charge line?

780 is not a required code to bill for telehealth services. The service code can be on the line with revenue Code 780 or a different line. Providers will be paid at parity based on the place of service. On UB claims forms, place of service isn't always included, which is why we include revenue code 780.

We are receiving notices from AIMS saying that some authorizations for DME/supplies are being suspended. Can you explain why this is happening?

As previously announced, NC is waiving PPA requirements for diagnostic tests and covered services that are medically necessary services, consistent with CDC guidance, for members diagnosed with COVID-19. Certain DME and supply codes are included in the PPA waiver to support the treatment of members

diagnosed with COVID-19. When a provider submits an authorization request with any of these codes, they will receive a response from AIM stating, "This service is not included in the Sleep Management Program at this time and does not require prior authorization." AIM implemented this waiver in their system on March 27, 2020. We will be posting a full list of codes that are included in a Provider News update next week.

I read that preventive exams are covered through telehealth services even without a physical exam. How do we document this?

While a complete, comprehensive physical exam isn't possible via telehealth, there also is a lot of counseling that needs to be completed during a patient visit. Also, keep in mind that regular evaluation and management codes can bill on counseling based on time, if the counseling is more than 50 percent of the time spent during the visit. We encourage providers to look at the CPT booklet to see what is covered under preventive visits as there are many codes included under counseling and other services that would be covered within a preventive visit.

How are copays/coinsurance/deductibles being handled for telehealth?

At this time copays/coinsurance/deductibles are handled the same for telehealth as per the member's benefits. On March 18, 2020, the Families First Coronavirus Response Act ("the Act") was signed into law. Under this act member cost share would be waived for visits, including telehealth visits, for COVID-19 testing and/or screening. Please visit our providers news story for details.

Do you have recommendations for HIPAA-compliant telehealth platforms?

The HHS Office for Civil Rights recently released an guidance on HIPAA regulations related to telehealth during the COVID-19 pandemic. We do not make recommendations about telehealth platforms, but we do encourage complying with HIPAA to the best of the provider's ability.

Are the telehealth measures just for COVID-19-related visits?

The telehealth measures apply to all visits, regardless of if it's related to COVID-19 or not. Visit our coronavirus provider webpage for more details on what is included.

How do I know what member segments are eligible for telehealth?

This applies to Blue Cross NC Commercial, NC State Health Plan and all Medicare Advantage members who are part of plans offered or administered by Blue Cross NC, including Experience Health. Information about FEP can be found at https://www.fepblue.org/coronavirus.

Do the calls/videos need to be recorded?

No.

Does it matter if the point of service for the telehealth visit is in the office or in the provider's home?

No.

Does a patient have to sign anything to receive telehealth services?

No.

Can we as providers make the personal choice to waive the copay and/or coinsurance and accept only what Blue Cross NC pays for telehealth?

Provider contracts require that the providers collect copay and/or coinsurancefor telehealth visits based on the patients benefit plan for now. On March 18, 2020, the Families First Coronavirus Response Act ("the Act") was signed into law. Under this act member cost share would be waived for visits, including telehealth visits, for COVID-19 testing and/or screening. Please visit our coronavirus provider webpage to view details.

Are there limitations on frequency or a waiting period between telehealth visits for a particular patient?

No.

Are facilities that are providing the video visits able to bill or is this only for professional billing?

Facilities can bill for telehealth services using revenue code 0780 along with the applicable procedure code.

How do opioids/controlled substances work with the expanded telehealth measures?

As of March 16, 2020, and continuing for as long as the Secretary's designation of a public health emergency remains in effect, DEA-registered practitioners in all areas of the United States may issue prescriptions for all schedule II-V controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met:

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice;
- The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system; and
- The practitioner is acting in accordance with applicable Federal and State laws.

Provided the practitioner satisfies the above requirements, the practitioner may issue a prescription either electronically (for schedules II-V) or by calling in an emergency schedule II prescription to the pharmacy, or by calling in a schedule III-V prescription to the pharmacy.

Important note: If the prescribing practitioner has previously conducted an in-person medical evaluation of the patient, the practitioner may issue a prescription for a controlled substance after having communicated with the patient via telemedicine, or any other means, regardless of whether a public health emergency has been declared by the Secretary of Health and Human Services, so long as the prescription is issued for a legitimate medical purpose and the practitioner is acting in the usual course of his/her professional practice. In addition, for the prescription to be valid, the practitioner must comply with applicable Federal and State laws.

Do I have to do anything special to get paid at parity for telehealth?

- Any claims submitted on or after March 6, 2020, will be reprocessed and paid at parity. You do not need to take additional actions.

- You can use any face-to-face visit codes for telehealth. However, you must also use POS 02. Additionally, if you used telephone only, you must use modifier -CR. Please note that any PPA requirements still apply when services are performed via telehealth.

I was not paid at parity for a telehealth claim I submitted after March 6, 2020. What do I do?

We apologize for any confusion as it has taken some time to configure our systems for these changes. Because of this, telehealth claims are being held for manual review and will be reprocessed starting Monday. Providers should wait until after they receive their explanations of payment (EOPs) prior to taking any action on these claims. We encourage you to join our Virtual Rounds on Monday, April 4 as we will have additional updates then

Can you clarify the use of modifiers? 95 and GT are close in description.

Modifier -95 is the CPT-based modifier that's live, *synchronous* audio-visual, and it's similar to HCPCS modifier -GT (-95 and -GT are from separate code sets). Modifier -GQ is for *asynchronous* services. BCNC commercial lines of business will **not accept -GQ**. -GQ is for FEP only based on their latest guidance.

We have patients who are primary Medicare with a Blue Cross NC Medicare Supplement secondary plan. Are those patients subject to the audio and visual requirement for payment at parity as per current Medicare guidelines?

Submit your claim using your original filing instructions with Medicare prime. If Medicare pays their part of the claim, the plan will pay the remaining balance based on the member's Medicare Supplement secondary plan.

How should virtual services provided by hospital on a UB be billed? E.g. Diabetic care previously billed under the hospital OP department. Observation services?

Use revenue code 0780 that applies specifically to telehealth for a facility outpatient services claim. Providers can also bill as they would for face to face with the only caveat that if the service is audio only, they must append the CR modifier to the CPT/HCPCS code on the claim line.

If we start HIPAA-compliant telehealth but lose video and must continue only with audio, do we include the CR modifier?

The provider can use their judgement. Review our updated Blue Cross NC Telehealth Corporate Reimbursement Policy.

Are substance abuse intensive outpatient programs able to use telehealth per Blue Cross NC?

Intensive outpatient programs (IOP) and partial hospitalization programs (PHP) may use telehealth services. However, they ***cannot*** use the revenue codes for the ***overall program***. Instead, they should use revenue codes for ***each individual service*** (e.g. therapy/counseling). IOPs and PHPs also should continue to use the same POS/bill type. Face-to-face per diem codes should ***not*** be used.

Can we bill global pregnancy prenatal telehealth visits?

Global maternity codes include ante-natal visits and delivery and post-partum care. The standard global is not something that can be performed by telehealth because it does include the delivery itself. Cognitive and counseling services outside of something that is procedural could certainly be done via telehealth. Antenatal and postpartum visits billed within the global OB may also be performed virtually, provided measures are in place to obtain necessary and accurate objective data (blood pressure, weight, urinalysis, etc).

If a patient has a telehealth visit and it is determined that they need to come in to be seen, how would you bill this claim?

The provider should only bill the higher level of encounter with the appropriate POS. The provider cannot bill for more than one E&M visit on any certain day.

How do the telehealth measures apply to behavioral health services?

For all specialties, including behavioral health, any services you can perform via telehealth, we would pay at parity. If there are services we don't reimburse in a face-to-face visit, we also wouldn't reimburse it for telehealth. For example, a physician to physician consult via telehealth would be denied as incidental as it is for face-to-face.

Is there a cost-sharing waiver for vendor-based telehealth services (MDLive, Teladoc)?

We announced on March 26, 2020, that we will waive cost sharing for all telehealth visits conducted through MDLive and/or Teladoc, regardless of if the visit is COVID-19 related. This will take effect for claims incurred on and after March 6, 2020 and will remain in effect until June 4. This is applicable ONLY to fully-insured individual and group customers and high deductible health plans that **offer MDLive or Teladoc as benefits** through their Blue Cross NC plan. We offered the provision to our Administrative Services Only (ASO) groups via an opt-out process (the deadline was March 31, 2020 to opt out).

Refilling medications

Does the "refill medications early" measure apply for opioids/controlled substances?

Yes, the early refill measure applies to all medications. Some pharmacies may wait on controlled substances based on professional discretion. Some quantity limits (in regard to dosage limits) still apply.

Would a new handwritten prescription be required each month for opioids/controlled substances?

State and federal regulations still apply. In the State of North Carolina, CII medications require a new handwritten prescription each month. However, in an emergency, a pharmacist may dispense a CII upon receiving an oral authorization of a prescribing practitioner provided that the quantity prescribed and dispensed is limited to the amount adequate to treat the patient during the emergency period. CIII, IV, & V medications do not require a new handwritten prescription each month. These prescriptions may be refilled five times.

Temporary notification-only requirement

What is the 24 hour notice requirement/PPA waiver you recently announced?

Blue Cross NC will temporarily suspend the following for **in-network providers located in North Carolina**:

- the requirement that providers obtain prior authorization for medically necessary emergent non-elective inpatient admissions and post-acute care services.

- concurrent review for appropriateness on inpatient acute care hospital admissions.

What does a provider need to do to notify us?

Providers are required to notify us within 24 hours of the patient's admission or receipt of service. Providers should use their normal channels to submit the notification, and they will receive a fax in response per the usual process. The typical information is needed in the notification (member name, member ID number, date of birth, diagnoses, physician and NPI number, rendering provider and NPI number- hospital, facility, home health (HH) agency, anticipated length of stay; if HH services requested: frequency and number).

What is the risk if a provider does not notify us?

The notification will result in an authorization entered into the medical management system. An authorization is required for the adjudication of the claim.

Why did we make this decision?

- Blue Cross NC is committed to helping members get the quality, affordable care they need. Part of that means supporting our front-line health care workers and ensuring access to care.
- It is anticipated that North Carolina hospitals will see a surge of patients in the next two weeks during the peak of the COVID-19 pandemic.
- These notifications ensure access to care for our members but also allow Blue Cross NC nurses to continue to assist members during their care transitions, including safe discharge to the home.
- The COVID-19 crisis is requiring everyone in the health care community to work together and do their part. Blue Cross NC is taking steps to help our members prepare, stay healthy and get the care they need. We will continue to respond to this crisis to best serve our customers.

When is this effective?

The initial period for this change is 14 calendar days, from April 9, 2020 through April 23, 2020. We have extended this measure for an additional 14 calendar days. The new expiration date is May 7, 2020. We will reevaluate as we get closer to this date to decide if another extension is needed.

What facilities/services are included?

During this temporary surge period, for certain services provided by in-network providers in North Carolina, Blue Cross NC will require notification only, and not request prior authorization, for medically necessary, emergent non-elective inpatient admissions and post-acute care services.

This may include:

- Emergency medical and behavioral health inpatient levels of care (including acute, Long Term Acute (LTAC), Acute Inpatient Rehabilitation (AIR) subacute rehabilitation (Rehab), and Skilled Nursing Facility (SNF).
- Home Health (HH) services

Prior authorization requirements will continue for other services as normal, including elective surgery.

Why did you select these facilities/services to be included?

We chose these facilities/services for two reasons:

1. Services that we included are medically necessary and required to allow patients to be moved urgently to the safest and most appropriate site of care.
2. We want to most efficiently use the limited health care resources available to respond to the COVID-19 pandemic.

What services will not require concurrent review for appropriateness?

During this temporary surge period, and for the applicable members, concurrent review for appropriateness will be suspended for **inpatient acute care hospital admissions**.

For other levels of care, concurrent review will continue. (This includes services provided at inpatient rehabilitation centers, long term acute hospital, and skilled nursing facilities.)

- We expect some facilities will still be able to provide records, and we will use our on-site nurse reviewers and electronic medical record (EMR) access to perform transitions of care and discharge planning.
- In recognition of the anticipated difficulties for inpatient acute care facilities to respond to records requests and to relieve their administrative burden in favor of clinical care, we will suspend making routine staff requests for inpatient acute care hospital clinical progress notes during this time period.

What services still require prior authorization and medical necessity review during this surge?

Prior authorization and medical necessity review **will continue, as normal,** for:

- Federal Employee Program customers
- Blue Card Host members
- Out-of-network providers
- Benefit exception requests by non-participating providers to be paid at in-network level (citing access to care standards). Members may receive services from non-participating providers at the out of network benefit level listed in their member benefit booklet but may face higher out of pocket costs.
- Out of state emergent/urgent facility admissions
- Services at residential treatment centers
- Durable Medical Equipment
- Blue Cross NC's pharmacy plans

Will Blue Cross NC continue to review requests for elective procedures that require prior authorization during this surge?

Yes. Requests for elective procedures that require prior authorization will continue to be reviewed.

To which member segments does this 24-hour notification apply?

- Individual, under-65 customers
- Fully-insured group customers
- State Health Plan customers
- Self-funded (ASO) group customers
- Medicare customers

Which member segments are excluded?

- Federal Employee Program (FEP) customers
- Blue Card Host (IPP) members (members of other Blue Cross and Blue Shield plans who visit providers in North Carolina)
- Blue Cross NC members living or receiving care out of state
    - Blue Cross NC will work with providers and hospitals in identified COVID-19 "hot spots" across the country, to apply these temporary measures in those areas where possible.
- Note: We cannot guarantee benefits or payments for FEP or IPP members. Providers and members should contact those plans for more information on benefits and reimbursement.

Will these measures apply to Blue Cross NC members seek care out-of-state?

There are identified COVID-19 "hot spots" across the country. Blue Cross NC will work with providers and hospitals in those areas, in order to apply these temporary measures where possible.
For out-of-state members, we will enter an authorization when we are notified of the admission. We also will be reviewing any claims that suspend for medical necessity before denying the claim. We realize the providers are not contractually obligated, however, we are going to do our best effort on this end to support our members and groups during this pandemic.

Why is COVID-19 coverage different for patients who see NC providers but are enrolled on an out of state Blue Cross Plan?

Inter-Plan Programs (IPP) enable members traveling or living in another plan's service area to receive their home benefits while away. A provider may be treating a patient who is physically in North Carolina, but they may have a Blue Cross and Blue Shield plan that is not Blue Cross NC. These patients would be considered an IPP member to us because they're not Blue Cross NC members. This is why you might see differences in reimbursement or claim submission guidelines. We cannot control or guarantee any benefits or payments for IPP plans, similar to how we cannot control or guarantee benefits or payments for FEP members. You should ask the member to check the back of their insurance card and provide you with the contact information listed for benefit verification. If you cannot reach the patient's home plan, you can contact us via the Provider Blue Line (800-214-4844) to help you escalate. You also can visit the Blue Cross and Blue Shield Association's Coronavirus Updates page to find out how local Blue Cross and Blue Shield companies are responding to the pandemic.

Is this measure applicable to out-of-network (OON) providers?

No. Out-of-network providers are still required to seek prior authorization.

Are we waiving post-service review?

The Medical Review team has a desktop procedure to address how and when to request medical records, what is included and what is excluded. They will collaborate with other business units to optimize existing processes.

How do these changes affect payment integrity?

Our post-service payment review processes for payment integrity will continue.

Are providers still required to follow Blue Cross NC's medical policy guidelines while these temporary measures are in place?

Yes. We are temporarily alleviating the burden of providing records in some cases, but in-network providers are still contractually obligated to follow Blue Cross NC's medical policy guidelines.

COVID-19 Testing

What does the cost-share waiver for COVID-19 testing include?

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) will provide coverage and waive cost-sharing (deductibles, copayments, and coinsurance) for COVID-19 testing or for a doctor visit to determine if testing is necessary. Specifically, there will be no member cost-share for COVID-19 testing or screenings through virtual care visits, outpatient office visits, urgent care visits or ER visits.

Included in this cost-share waiver are COVID-19 diagnostic (molecular) and antibody (serology) tests that are **prescribed by a physician** and have been **cleared, approved or given emergency use authorization (EUA) by the FDA**.

How do I know if a test has been cleared, approved or given emergency authorization by the FDA?

Please visit the FDA website for the most up-to-date information. Additionally, the FDA has issued warnings about fraudulent coronavirus diagnostic, prevention and treatment claims. If you are aware of fraudulent test kids for COVID-19, please report them to the FDA.

How do I get tested? How do I know if I need to get tested?

Call your primary care provider. They will be able to tell you if you need a test, which test is appropriate (COVID-19 diagnostic test vs. antibody test), and how to get it. The CDC also offers a "Self-Checker." Use this tool as a guide if you feel unwell and want to know if you should seek appropriate medical care.

Is antibody testing included in the cost-share waiver for COVID-19 testing?

Antibody (serology) tests that are **prescribed by a physician** and have been **cleared, approved or given emergency use authorization (EUA) by the FDA** are included. Visit the FDA website to see a list of all test kit manufacturers and commercial laboratories that have received an EUA.

Is there guidance on how or when to use an antibody test?

The FDA has issued guidance to providers on antibody testing. We recommend that providers visit the FDA website for more details.

If a doctor orders a follow-up COVID-19 diagnostic (molecular) test after an antibody test is completed, will that be covered under the cost-share waiver?

Yes, a follow-up COVID-19 diagnostic (molecular) test that has been cleared, approved or authorized by the FDA and ordered by a provider would be covered. The FDA recommends that because the antibody test does not rule out a COVID-19 infection, providers should consider a follow-up molecular diagnostic test.

What is antibody testing?

Antibody (serology) tests tell us if your body is fighting an infection caused by a virus and if it's developing an immunity to the virus. It does not detect the virus itself. Learn more about these tests on the FDA website.

How should providers handle coding and claims submissions for the antibody test?

The AMA released CPT codes 86328 and 86769 to be used on or after April 10.

Please hold antibody test claims until May 1, 2020. If you submit a claim prior to May 1, 2020, and it is declined, please re-submit the claim after May 1, 2020. Doing so will allow us the time to configure our system.