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

New from 2/15/2021 Virtual Rounds

When should the -CS modifier appear in the first position when coding for COVID-19 testing or visits to determine if testing is necessary?

The -CS modifier should always appear in first position unless another modifier is required for reimbursement purposes.

Is the -CS modifier needed on the M0239 (antibody monoclonal infusion)? Does it require a specific diagnosis code? If the -CS modifier is accidentally added, will the claim still process or will it deny? Does Z23 need to be added?

For commercial plans:

- The -CS modifier is not required on the monoclonal antibody infusion code, and the diagnosis code should be U07.1. If the -CS modifier is added, the claim will still process and pay.
- Z23 is the diagnosis code for an encounter for immunization. M0239 is not a vaccine but a treatment and Z23 should not be used.

For Medicare Advantage plans:

- Providers can bill for the administration of the COVID-19 monoclonal antibody infusion on a single claim for COVID-19 monoclonal antibody administration or submit claims on a roster bill, in accordance with the FDA EUA for each product.
- When COVID-19 monoclonal antibody doses are provided by the government without charge, providers should only bill for the administration. Health care providers should not include the COVID-19 monoclonal antibody codes on the claim when the product is provided for free.
- Health care providers who provide these services to enrollees in a Medicare Advantage Plan should submit claims for monoclonal antibodies to treat COVID-19 that are covered by Part B in

accordance with Section 3713 of the CARES Act to Original Medicare for all patients enrolled in Medicare Advantage in 2020 and 2021.

If a patient has a strep and/or flu test in conjunction with a COVID-19 test, where should we put the Z code?

If the provider chooses to use the Z20.822 code to signify a cost-share waiver for visits to determine if a COVID-19 test is needed for a commercial member, it should be used as the primary diagnosis on each claim line for any service that you feel was required to be done to determine the need for a COVID-19 test. This Z code can also be applied to the COVID-19 test itself. However, our recommendation is to continue using the -CS modifier for services to determine if a COVID-19 test is needed for commercial claims.

I work for an urgent care that is going to be administering the COVID-19 test at a facility that is not our office site. What is the appropriate place of service?

You can use place of service (60) – mass immunization site. Please keep in mind, Blue Cross NC does not accept roster billing. You must submit a claim per member.

Can you clarify how the Medicare Sequestration reduction will be applied to participating providers?

Per the recent Provider News article update published on Feb. 11, 2021, for dates of service from May 1, 2020, through December 31, 2020, and from February 15, 2021, through March 31, 2021, Blue Cross NC will not apply the Medicare 2 percent sequestration reduction in payments being made to participating providers. When CMS first suspended sequestration payment reductions in 2020, Blue Cross NC announced that it would align with CMS and suspend application of our sequestration reimbursement policy through December 31, 2020. When Congress passed the Consolidated Appropriations Act at the end of December, Blue Cross NC decided, again, to align with CMS and continue the suspension of our reimbursement policy. However, the law was passed so late in the year that we had already passed the point where we could continue the suspension without interruption due to additional system configuration that was required. Therefore, we decided to reinstate the suspension beginning on February 15, 2021, and running through March 31, 2021. We will not be adjusting claims for the interim period between January 1, 2021, and February 14, 2021.

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.

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.

What is Blue Cross NC doing to help members who are experiencing financial hardship and are unable to pay premiums? Also, is Blue e updated regularly enough to reflect if a member's benefits have lapsed?

Blue Cross NC has extended grace periods on premium payments for all customer types, such as employer groups, Medicare Advantage plans offered or administered by Blue Cross NC, and the ACA individual and family plans. These premium deferrals generally apply to March, April and May premiums. As the situation evolves, we will continue to evaluate how best to help our members. Blue e is updated nightly so it will have updated information based on that frequency of updates.

Will you be extending the timely filing limit for providers? If so, what is the date range?

Currently, we are still operating on the normal filing limit timeframes for providers. However, we continue to evaluate this and all measures related to COVID-19 and will communicate with you if this changes.

Does Blue Cross NC want any indication on a global delivery charge if any of the prenatal visits were performed via video?

If it's not something that is usually paid/billed outside of the global delivery charge, then you wouldn't need to file a separate claim for telehealth because you wouldn't do so if face to face. However, if it is a service that is separately reimbursable outside the global delivery charge, then you would follow the guidelines on how to code/bill for telehealth visits on our provider webpage.

What is the scope of COVID-19 services that will be paid at PPO rates for out-of-network providers? Will you publish a detailed list of diagnosis and/ or procedure codes?

Our out-of-network reimbursement policy for COVID-19 applies to COVID-19 diagnostic testing, the health care visit to determine if testing is necessary and treatments for a member with a positive COVID-19 diagnosis or suspected diagnosis. If a provider disagrees that our reasonable payment is payment in full, providers should contact us and not bill the member. For COVID-19 treatment visits when the diagnosis has been confirmed, use the ICD-10 diagnostic code U07.1, COVID-19 virus identified, in the primary position. For COVID-19 screening visits use either ICD-10 code Z03.818 in the primary position for a possible COVID-19 exposure or ICD-19 Z20.828 for a suspected COVID-19 exposure. For additional details on our COVID-19 out-of-network reimbursement policy, read our Provider News update.

Has there been any information published about extending prior authorizations for elective procedures that have already been approved?

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) is extending existing authorizations for in-network providers for all commercial elective inpatient admissions and most commercial outpatient services to be performed on or before October 1, 2020. Blue Cross NC recognizes that call volume from patients likely will increase post-pandemic and that providers have delayed elective services to help flatten the curve. This measure seeks to support providers by eliminating the need to conduct additional medical necessity review on a procedure that has already been approved. ***Please see the Provider News update for details.***

Please Note: Elective procedures still require a medical necessity review and are not part of recent prior authorization waivers. Providers scheduling procedures that have not been previously authorized should submit a prior authorization for review utilizing the normal process.

Are there specific documentation requirements for 99072?

We are still in the process of determining coverage and reimbursement for this code. We will provide more specifics, including documentation requirements, when communicate our decisions.

If an urgent care center plans to go out and give flu shots and, in the future, COVID-19 vaccines at local companies, what place of service should they use?

Use place of service 15 (mobile unit).

When a member's cost-share is waived, how does that impact the payment to the provider?

The amount paid to provider increases by the amount of the member's cost share. The allowed amount stays the same.

Are you planning to put the form for requesting authorization for psych testing online? (Note: This question is unrelated to COVID-19 but is a general behavioral health question.)

It is online now.

Does Blue Cross NC cover or do you plan to cover self-monitored blood pressure monitoring (CPT codes 99473 and 99474)?

Currently, we do cover those codes. However, at the moment they're considered as part of other physician services so there's no additional reimbursement.

Is Blue Cross NC considering covering interprofessional consult codes during COVID-19? During the PHE, there is increased use of this service in inpatient settings to protect providers. CPT 99446-99449 and 99451 are of interest.

Those codes will not be denied. You can submit them. Right now, they're not separately reimbursable.

I got an email about the NC HealthConnex requirement. How will that impact if we can treat State Health Plan members?

Please see the latest Provider News update on the NC HealthConnex requirement.

For non-telehealth claims, if we need to submit a corrected claim, can we do that now or do we have to wait after a certain date?

For non-telehealth claims, you can submit a corrected claim at any time. We are asking providers to hold sending corrected claims for telehealth-specific claims because we are currently adjusting those reimbursements and hope to have most of them corrected soon.

Will members be made aware of changes that affect their benefits?

Yes, we have been updating members about our COVID-19 relief measures through a variety of communication channels, but the primary one is the Blue Cross NC COVID-19 member resources webpage.

Are you going to continue doing Virtual Rounds?

Yes, we plan to continue hosting Virtual Rounds as long as there is demand from providers. However, based on a poll we did during the May 26 session, we are making these biweekly (i.e. every other week) instead of weekly starting after June 1. We will host a session on June 1, but then the next session will be June 15. If you chose the option to attend all future sessions when you originally registered, you do not need to do anything. If you are selecting specific sessions, you will need to register again. We will continue to evaluate the frequency and demand for these sessions and adjust as needed.

In light of COVID-19, will 2021 E/M changes still be implemented?

Unless the CMS or CPT provides an update, Blue Cross NC will be following the guidelines outlined in the CMS final rule that will take effect on Jan. 1, 2021.

Are you reviewing the Medicare Star cut points for the quality measures?

Blue Cross NC will be following the CMS cut points. However, evaluation of providers' quality performance depends on the program in which they participate. Please email your program contact if you have questions specific to your practice.

I've submitted information on the claims escalation form a few weeks ago but haven't gotten a response. How do we follow up on those submissions?

The Claims Escalation team generally responds to inquiries in 7-10 business days. If it's been more than 10 business days, please send an email ***with the claim ID*** to covid19claimsfallout@bcbsnc.com.

How can you determine if a patient has no cost-sharing for an out-of-state provider?

If the patient is not a Blue Cross NC member but instead is a member of another Blues plan, use the phone number on the back of the patient's ID card to verify benefits. If you are an out-of-state provider and are seeing a Blue Cross NC member, please contact our customer service department to verify benefits. You also can visit the Blue Cross Blue Shield Association website to find contact information for other local Blues plans.

Do you have any information about the new High Performance Network product?

Blue Cross NC announced it will offer a new Blue High Performance Network℠ (Blue HPN℠) in the Charlotte area beginning January 2021. More details will be announced soon on our Important News page for providers (this information also will be added to our weekly eBriefs newsletter once available for providers who subscribe to that communication). In the meantime, you can find high-level details in our recent press release.

We submitted claims with QW with 87635 with QW modifier but these were denied. Can you tell us why?

We did identify an issue in our system that has been fixed. You can resubmit your claims, and they should process.

What documentation requirements exist for code 99072?

There are no specific documentation requirements for that code. Click here to read about coding and reimbursement details for 99072.

Where can I get more information on the Open Bed Campaign?

You can find more information at https://www.vaxpaces.com/.

Will Blue Cross NC bring back the post-acute care prior authorization waiver?

We are continually evaluating our measures based on the current state of the pandemic and will notify providers if we make any updates.

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.

Are Licensed Professional Counselors (LPC) and Licensed Clinical Social Workers (LCSW) included in the telehealth reimbursement policy?

Any provider eligible to bill face-to-face services may submit claims for services performed via telehealth.

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. We had a higher volume of telehealth claims that require adjustment than anticipated. As such, the timeline for completing the process has been extended to the end of May. There is no action needed by providers at this time to correct claims. Resubmissions may further increase the volume and potentially cause errors in provider's reimbursement. We apologize for the delay; however, we want to be certain that your additional reimbursement and reimbursement on claims going forward are correct and what is expected.

Why are some of my telehealth claims being paid at a higher rate than face-to-face visits and some being paid lower?

For the claims being paid at a higher rate, it can depend on the contract/fee schedule. For those being paid at a lower rate, we are adjusting those claims automatically.

If I know that I coded my telehealth claim incorrectly, should I wait until my explanation of payment (EOP) is posted, or can I send a corrected claim now?

We had a higher volume of telehealth claims that require adjustment than anticipated. There is no action needed by providers at this time to correct claims. Resubmissions may further increase the volume and potentially cause errors in provider's reimbursement. We apologize for the delay; however, we want to be certain that your additional reimbursement and reimbursement on claims going forward are correct and what is expected.

Are you planning to continue a similar telehealth policy after COVID-19?

We are continually evaluating our reimbursement and coverage policies and will carry on this process as the pandemic evolves.

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.

Can you review how telehealth coverage and reimbursement applies to out-of-state patients who are being seen in North Carolina or patients from North Carolina being seen outside of the state?

Patient scenario	**Benefit coverage**	**Provider reimbursement**
Patient is a Blue Cross NC member but is receiving care outside of North Carolina (i.e. Inter-Plan Program/IPP Home). ***Example:*** Patient has a Blue Cross NC commercial plan but is currently living in Texas. The patient has a physical therapy telehealth visit with a PT provider practicing i n Texas.	Blue Cross NC's member benefits and related cost-sharing would apply. In the example, the normal cost-sharing (copays, deductibles, coinsurance) dictated by the patient's Blue Cross NC commercial benefits would apply .	The reimbursement to providers for telehealth is dependent upon the Blues plan where the provider is practicing. The provider should contact the plan where they practice for reimbursement information. In the example, BlueCross BlueShield of Texas reimbursement policy would apply.
Patient is a member of another local Blue Cross and Blue Shield plan but is receiving care in North Carolina (i.e. IPP Host).	The patient's home plan benefits apply. In the example scenario, BlueCross BlueShield of Texas member benefits apply.	The host plan's reimbursement policy applies. The provider should contact the plan where they practice for reimbursement information.

Example: Patient is a member of BlueCross BlueShield of Texas but is currently living in North Carolina. The patient has a physical therapy telehealth visit with a PT provider practicing in North Carolina.		In the example scenario, BlueCross NC reimbursement policy applies, but BCBS TX benefits could override our payment policy.

I have determined that my client falls into the IPP Host category. I have called the home plan (Texas) and was told that the client does have Telehealth coverage with no cost share. As a host provider, I have submitted a claim to Blue Cross NC, and the cost was identified as a deductible charge. Can I submit directly to the claims department in Texas or is there another way you would advise me to rectify this?

There may be specific coding requirements in order for the claim to pay with no cost share. They should contact the home plan and ask if there are any specific coding requirements. This information can normally be found on the provider section of the home plan's website. Host providers should submit the claim to the plan where they practice.

Are there limits to telehealth visits (overall number of visits, number of visits per day for the patient, number of visits per practice)? Can a patient have a regular telehealth visit with a physician and also have behavioral health visit the same day with another provider under the same Tax ID number (different billing NPI)?

Providers should follow the same frequency limits and guidelines as are in place for face-to-face visits. The same claims editing will apply.

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?

For commercial members, use face-to-face CPT or HCPCS codes plus Place of Service (02), unless you are an urgent care or facility. Urgent care and facility providers should bill the same as if the services were face to face. If it's an audio-only encounter, use the CR modifier. 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 providing telehealth services to a MA member and use POS 02, the reimbursement configuration may not apply your claim to the correct fee schedule. 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.

CMS recently held Office Hours where they advised that providers should use the -95 modifier because they added 99441-3 to the telehealth policy. Do we need to add this modifier for members of your Medicare Advantage plans?

The -95 modifier should be used for all synchronous audio-video telehealth encounters, and it should be used when billing 99441-99443 to allow for reimbursement at the higher rate. ***(Updated answer as of 5/20/2020)***

If we filed an incorrect place of service for a patient on a Blue Cross NC Medicare Advantage plan and got paid incorrectly, do we send a corrected claim with Place of Service 11?

Please send a corrected claim.

Is Blue Cross NC following CMS guidelines that state CMS is not requiring a history or exam to be used in selecting an E/M service via telehealth? This temporary policy is similar to the policy that will apply to all office/outpatient E/M services beginning in 2021 under policies finalized in the CY 2020 PFS final rule.

We are not requiring an exam to be used in selecting the level of E&M service via telehealth during the pandemic.

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?

Use the same revenue codes as if the services were being performed face to face.

For facility billing/UB, when is modifier -CR and a condition code needed?

Modifier -CR is needed only if it is an audio-only or telephone telehealth consult. Condition code DR should be used when reporting COVID-19-related services on both inpatient and outpatient claims.

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.

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?

Providers should 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. The providers can use the revenue codes that they normally bill. IOPs and PHPs also should continue to use the same place of service/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).

If we incorrectly filed a telehealth claim with the -GT modifier, will we be denied? Will you require that we resubmit with the corrected coding to be paid at parity?

You do not have to resubmit a corrected claim. However, if you received an adjusted claim that is still incorrect, please contact Provider Services.

Is Blue Cross NC using the same E/M for telephone only codes?

Yes. For telephone only, bill the same CPT as you would for face to face and add –02 place of service and CR modifier for commercial and NC SHP plans.

For time-based telemedicine visits, can time with clinical staff be counted or only QHP time (i.e. time with FNP, MD, PA, etc.)?

Time-based billing is based on when 50 percent of the time is related to counseling for that E/M code. Time is inclusive of all face-to-face time. It is inclusive on total time spent with the patient. We recommend you look in the CPT booklet as it gives you a breakout on what the typical time is, in addition to other guidance in CPT instructions. OBJ

For telemedicine coding/billing, is it based on MDM or time?

Use the correct coding as you would for a face-to-face visit.

Will telehealth claims be used for risk scoring and care gap closures under Blue Premier?

For risk scoring, the telehealth claim must be an audio-visual (i.e. video component required; can't be audio only) claim and acceptable to CMS for risk scoring.

CMS has revised their policy to specify that the office/outpatient E/M level selection for these services when furnished via telehealth can be based on MDM or time. They have removed any requirements regarding documentation of history and/or physical exam in the medical record. However, it remains the expectation that providers will document visits as necessary to ensure quality and continuity of care. This includes documentation and coding of all conditions that coexist at the time of the encounter/visit and require or affect patient care treatment or management. Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).

For care gap closures, NCQA allows for the use of telehealth, in place of in-person visits, in many of their measures. In the past few years, NCQA updated their HEDIS measures to include specific telehealth modalities that were supported by research evidence, in addition to in-person care. Please refer to HEDIS measure specifications for more information on which measures allow telehealth services.

When examining the 2020 HEDIS specifications surrounding care gaps for the Adult BMI (ABA) measure and the Controlling High Blood Pressure (CBP) specifically, HEDIS guideline 39 states that member collected biometric values including BP, BMI, height and weight cannot be used for HEDIS reporting. Based on that guideline, those measures cannot be closed with telehealth visits. CBP does allow the use of remote BP monitoring devices if the information is electronically transmitted to the provider.

I received a denial on a telehealth claim that was a non-COVID-related visit. Can you tell me why?

If you have questions about a denial on a telehealth claim, please submit details via this form.

How do we handle billing for patients that are late to telehealth visits? Are we able to apply a late fee?

Blue Cross NC does not cover charges for missed appointments. You may bill members directly for missed appointments only if this is a standard procedure for your practice, and the member has previously received a written statement of this procedure, or your standard procedure for missed appointments is posted in your office in a prominent location.

We conduct "hybrid visits" where the provider sees a patient via telemedicine and then a patient presents to the clinic to be swabbed in the parking lot. What POS do we use for the visit? And what POS for the COVID-19 swabbing?

The visit via telemedicine can be coded as POS 02 with your normal evaluation management code. In this case, the COVID-19 swab should be coded as POS 20 because it is being performed in an urgent care setting.

A COVID-19 swab without other services should be coded as 99211 with a POS of wherever the swab is being performed. If it's being done in a provider's office, it will typically bill on a 1500 or professional claim form. Facilities and those billing on the UB-04 form should use HCPCS code C9083. You should not be using POS 02 for the swab because that code is reserved for services provided via telemedicine.

We are seeing these patients via telehealth the same day they present to the clinic to be swabbed. Can we send in two invoices on the same day – one with POS 02 for the telemedicine E/M and another with POS 20 for the COVID-19 swab? Or would we only send one invoice, including both the telemedicine and the swab?

Providers who see a patient via telehealth the same day the patient presents to the clinic to be swabbed should submit two separate invoices – the first with POS 02 and the other (the swab) with POS 20.

If we're an urgent care or facility provider and used POS 02 instead of billing the same as face to face for telehealth claims, do we need to submit a corrected claim?

If the claims are related to COVID-19 and would be eligible under the cost-share waiver, we will reprocess those automatically. If it is unrelated to COVID-19 and the concern is around being paid at parity, the reimbursement for urgent care and/or other facilities is the same for telehealth as it would be for face to face so there wouldn't be a need to reprocess.

What about telehealth urgent care or facility claims for out-of-state/Inter-Plan Program Host members that were coded incorrectly?

Blue Cross NC only provides reimbursement to providers for IPP Host members (i.e. members with out-of-state Blue Cross plans seeing a provider in North Carolina). If the provider feels that they are being reimbursed differently for POS 02 than for POS 20, the provider should first contact the member's home plan for any coding requirements and then, if need be, contact Blue Cross NC Provider Services for assistance.

We are finding that 99358 is not being paid when billed with POS 02. Can you tell us why?

99358 is an incidental code and will not be reimbursed separately, regardless of the place of service.

On a UB-04, how are we to bill for a telephone/audio-only visit? UB-04 does not have a Place of Service as a 1500 does. Would modifier -95 be valid?

Yes, modifier -95 would be appropriate for telephone/audio visits on a UB-04 form.

COVID-19 Testing, Visits, Treatment

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

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) will waive member cost-sharing (deductibles, copayments, and coinsurance) for allowed charges for COVID-19 testing or for a doctor visit to determine if testing is necessary as long as the test is medically necessary, ordered by a licensed provider and cleared, approved or given emergency use authorization (EUA) by the FDA. Specifically, there will be no member cost-share for COVID-19 testing or health care visits to determine if COVID-19 testing is needed through virtual care visits, outpatient office visits, urgent care visits or ER visits.

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.

Can you clarify if patients can be tested at lab drawing stations? LabCorp is saying they cannot do this. Also, can testing be done without a provider's order?

Neither LabCorp nor Quest will perform the COVID-19 diagnostic (molecular) test in the patient service center due to the high risk of transmitting infection. If a patient is being swabbed and is actively infected, they can transmit the virus. For our cost-share waiver to apply, the test must be ordered by a provider, be medically necessary and be FDA cleared, approved or authorized.

Will Blue Cross NC cover more than one COVID-19 molecular and/or antibody test by the same practice? If so, is there a specific amount of time that must pass between tests?

Blue Cross NC will only cover one type of test per date of service. There is no set frequency if ordered by the physician and is medically necessary.

Will Blue Cross NC cover two COVID-19 tests from two separate facilities on the same date of service for the same member?

Blue Cross NC will only cover one of each type of test per date of service regardless of provider.

When should we use the -CS modifier?

- Effective for dates of service on or after Aug. 1, 2020, providers should use the -CS modifier to indicate any COVID-19 testing-related services that result in an order for or administration of a COVID-19 test.
- The -CS modifier should be applied to diagnostic imaging, labs and physician encounters (both face-to-face and telehealth) to determine if testing is needed for individuals with COVID-19 symptoms.
- Please do not use the -CS modifier if you are screening a patient for COVID-19 (i.e., pre-op testing services). The modifier only should be used for visits and services to determine if COVID-19 testing is necessary.
- The -CS modifier is not required for the COVID-19 test itself.
- If another modifier is required for reimbursement purposes (e.g. -26 on a radiology procedure or -CR to indicate audio only for a commercial telehealth visit), the -CS modifier may be placed in the second or third position.
- Do not use the -CS modifier for treatment of COVID-19 or any other diagnosis. This is the most common error we have seen.
- This coding guidance applies to Blue Cross NC fully-insured and State Health Plan members.
- Medicare Advantage plans offered or administered by Blue Cross NC, including Experience Health, should follow CMS guidelines for use of the -CS modifier.
- Visit this page for more details on coding guidance.

For dates of service before Aug. 1, 2020, how should providers code for COVID-19 testing or clinic visits to determine if testing is needed?

For dates of service ***before*** Aug. 1, 2020, use Z03.818 or Z20.828 as the primary diagnostic code. For dates of service ***on or after*** Aug. 1, 2020, append the -CS modifier to procedure codes.

Does the Z code need to be in the primary position for visits to determine if COVID-19 testing is needed? If we have claims that need reprocessing due to the Z code not being in the primary position, what should we do?

Yes, the Z code must be in the primary position for the member cost share to be waived.

If you have claims that need reprocessing, please complete this form, and a member of our claims evaluation team will respond. Also, please review our coding guidance for COVID-19 testing and visits/calls to determine if testing is needed.

Does the -CS modifier apply to pre-op screening?

Please do not use the -CS modifier if you are screening a patient for COVID-19 (i.e., routine pre-op testing services). The modifier only should be used for visits and services to determine if COVID-19 testing is necessary.

For COVID-19 testing as a preoperative service for outpatient surgery at a hospital or ASC, what is the coding guidance?

For COVID-19 testing as a preoperative service for outpatient surgery at a hospital or ASC, payments are processed according to a provider's contract with Blue Cross NC.

For symptomatic patients that result in a negative test, what should be the sequence of coding?

For dates of service on or after Aug. 1, 2020, Z20.828 can be either in primary or secondary position as long as the -CS modifier is included with the procedure code. For dates of service before Aug. 1, 2020, the Z encounter code should be in the primary position.

For professional claims, if the diagnosis order has the COVID-19 code in the secondary position but the facility diagnosis order has it primary, how will the cost-share waiver be applied?

We look at each claim separately. If one claim has the diagnosis code for COVID-19 in the secondary position, it will not waive the cost share for the member. For the claim that has the diagnosis code in the primary position, it will waive the cost share for the member.

For out-of-state/Inter-Plan Program Host COVID-19 claims that providers believe should've received a cost-share waiver and didn't, what should providers do? What about telehealth urgent care or facility claims for out-of-state/Inter-Plan Program Host members that were coded incorrectly?

Blue Cross NC only provides reimbursement to providers for IPP Host members (i.e. members with out-of-state Blue Cross plans seeing a provider in North Carolina). As such, if the claim is for an IPP Host member for a COVID-19 related service, the provider should first contact the member's home plan (use the number on the back of the ID card) as they would determine the services and diagnoses that would be eligible for any cost-share waivers under their plan. If there was an error in the application of a cost-share waiver or if the provider was unable to obtain any information, then the provider should reach out to Blue Cross NC Provider Services for further instructions on how to resubmit claims to have the member's cost share waived. The same process also should be followed for telehealth claims. If the provider feels that they are being reimbursed differently for POS 02 than for POS 20, the provider should first contact the member's home plan for any coding requirements and then, if need be, contact Blue Cross NC Provider Services for assistance.

Who should be billed for COVID-19 testing – Blue Cross NC or Avalon?

Tests should be billed according to the provider contract.

Is there a specific diagnosis code that should also be applied to the claim when we're using the -CS modifier?

You should use the diagnosis code that is most appropriate based on the member's symptoms or diagnosis.

The -CS modifier guidance for visits to determine if COVID-19 testing is needed goes into effect on Aug. 1, 2020. How should we code for these visits before Aug. 1?

For date of service prior to 8/1, please review our coding guidance for COVID-19 testing and visits/calls to determine if testing is needed.

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

Antibody (serology) tests that are **prescribed by a provider, are medically necessary** 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 molecular test after an antibody test is completed, will that be covered under the cost-share waiver?

Yes, a follow-up COVID-19 diagnostic test that has been cleared, approved or authorized by the FDA, is medically necessary 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.

The American Medical Association (AMA) released CPT codes 86328 and 86769 for antibody testing. What is the fee schedule for these codes?

CMS is our usual pricing source, and they have not released fees for those codes. As such, we are still in the process of establishing our fee schedule. However, if a lab is contracted with Avalon, we do have fees associated with that. You can log into Blue e to see what those are.

Are there any mental health diagnoses for patients who have or are recovering from COVID-19 covered under the cost-share waiver?

There are not any that we are aware of at this time. We encourage providers to code correctly given the patient's condition. If there are new COVID-19 codes that are approved, we will communicate those to you.

Can C9803 be billed in addition to an E/M for outpatient office specimen collection?

C9803 is only to be used by facilities or those providers who bill on the UB04 claim. For professionals, it should be billed with 99211 if only collecting a specimen. Otherwise, it is included in the reimbursement for the actual E/M visit.

If we are not performing the antibody test in office, should we or should we not bill using 36415?

For Blue Cross NC members, it isn't necessary to include that code as it will be included with any blood test services performed in the office visit.

Are other procedures like X-rays, scans or labs that were performed during a visit for a patient with a suspected or confirmed COVID-19 diagnosis included in the cost-share waiver?

Leading up to the actual COVID-19 test, we are covering chest X-rays and the rapid flu test along with either the telehealth, office visit, or urgent care or ER visits. COVID-19-related treatments performed for someone with a confirmed diagnosis also are covered under the COVID-19 treatment cost share waiver.

Are preventive medical counseling visits (e.g. nutritional counseling) via telehealth covered under a cost-share waiver?

If it's a preventive service covered under the Affordable Care Act, then we would continue to cover it at 100 percent without a cost-share to the member.

Is the State Health Plan reimbursing providers for antibody testing?

Yes, State Health Plan is covering antibody testing consistent with the Families First Coronavirus Response Act. To be covered, the test must be medically necessary, ordered by a physician and FDA cleared, approved or authorized.

Is there a policy indicating the diagnostic code for the antibody test?

You'd normally code with the diagnosis that pertains to why the person needs the test. No specific diagnosis needed for that with the cost-share waiver, but use the ICD-10 coding guidelines for the diagnosis that pertains to the reason for the test.

Will HDHP members still have to pay their portion for both molecular and antibody testing?

We received confirmation from the federal government that HDHP members are included in the cost-share waiver for COVID-19 testing.

For collection of specimens for the COVID-19 PCR test, we were advised to hold claims until June 1. Are your systems configured now, or do we still need to wait?

Yes, our systems are configured for C9803, which is the collection code for the test. You no longer have to wait to submit these claims.

Should we be using code G2023 for specimen handling when we send out the COVID-19 test and antibody testing to the lab or should we use 99211?

For Medicare Advantage plans that Blue Cross NC offers or administers, including Experience Health, providers can use G2023. For commercial plans, including State Health Plan, providers can bill G2023. For cases of confirmed or suspected exposure to COVID-19, use one of the two diagnosis codes (Z03.818 encounter for observation for suspected exposure to other biological agents ruled out or Z20.828 contact with and (suspected) exposure to other viral communicable diseases). If the specimen collection

is at the same time as an office visit, the specimen collection is included in the E&M code and will not be reimbursed separately.

How is "medical necessity" determined for COVID-19 testing?

Medical necessity for all covered services, including COVID-19, is determined by a licensed health care provider for the diagnosis and management of a member's medical condition. This decision should be based upon the accepted standards of current medical practice. For additional guidance, review the resources below:

- Blue Cross NC Medical Necessity Policy
- Infectious Diseases Society of America guidelines on the diagnosis of COVID-19
- CDC guidance on COVID-19 testing

What diagnosis code should we use for a positive antibody test?

Based on our knowledge of antibody testing for COVID-19, there is not currently a clearly defined utility of this test for the medical management of an individual patient. The diagnosis code would be dependent on clinical diagnosis by the provider. However, if the patient had positive PCR test, then the ICD-10 code U07.1 for confirmed diagnosis would be appropriate.

If a patient comes in for antibody testing only, completely asymptomatic, would we still only use Z01.84, even if positive?

That would be a proper diagnosis code if there was no viral testing or if the viral test is negative.

Is the COVID-19 swab for a patient without symptoms payable with code 99211?

The only time a provider should use code 99211 is if the COVID-19 swab is the only service being performed. If the patient is also seeing a physician, the provider should not be using code 99211 because this should be included in the overall evaluation management code. This is regardless of whether the patient has symptoms or is asymptomatic.

We are seeing issues with age restrictions at testing sites, ie., not testing for children under 10 years of age or even under age 18 years. Is Blue Cross NC able to help providers know if there are restrictions for testing site by age? Is there a list of testing sites that list these age restrictions?

Blue Cross NC does not have an age restriction policy for COVID-19 testing. However, each testing site may impose their own policies. NCDHHS has a "Find My Testing Place" page on its website that includes details and policies for various testing sites across the state. Because these policies may change frequently, it is recommended to call the testing site before patients go in for testing.

If a patient is in a car or in a drive-up testing site, how should a professional provider bill for COVID-19 specimen collection?

A professional provider should bill 99211 with the -CS modifier.

I have had a few claims come back with copays for COVID-19 encounters. How do we ensure patients do not have copays?

For dates of service ***before*** Aug. 1, 2020, use Z03.818 or Z20.828 as the primary diagnostic code. For dates of service ***on or after*** Aug. 1, 2020, append the -CS modifier to procedure codes.

If there was an error in the application of a cost-share waiver, the provider should reach out to Blue Cross NC Provider Services for further instructions on how to resubmit claims to have the member's cost share waived.

If you have claims that need reprocessing, please complete this form, and a member of our claims evaluation team will respond.

If a patient is seen after hours for a possible COVID-19 diagnosis (Z03.818), would the cost-share waiver cover the after-hours visit?

For Commercial products, Blue Cross NC waives member cost share for evaluation of a possible COVID-19 diagnosis (Z03.818) for after-hours visits (99051) for POS 02 (telehealth) and POS 11 (office). For Commercial products billed with POS 20 (urgent care) or POS 23 (emergency department), and for Medicare Advantage products, there is no member cost share or additional provider reimbursement for after-hours visits (CPT 99050-99053), regardless of diagnosis.

If you have claims that need reprocessing, please complete this form, and a member of our claims evaluation team will respond.

Reminder: For dates of service ***before*** Aug. 1, 2020, use Z03.818 or Z20.828 as the primary diagnostic code. For dates of service ***on or after*** Aug. 1, 2020, append the -CS modifier to procedure codes.

Does the order in which diagnosis codes are listed matter when billing for patients who qualify for the cost-share waiver because we are seeing them due to a suspected exposure to COVID-19?

For dates of service on or after Aug. 1, 2020, the only requirement for us to identify claims where the cost share should be waived is the inclusion of the -CS modifier on each claim line that indicates a service that was performed during an encounter in which the decision was made to order or perform a COVID-19 test.

For dates of service prior to Aug. 1, please put Z03.818 or Z20.828 in the primary position.

Is there a limit to the number of COVID-19 tests you can have per month?

There is no limit per month if the physician deems each one as medically necessary. However, we will only cover one type of test per day. (i.e. If a COVID-19 test is administered twice to the same patient on the same day, only one test will be covered.)

If the patient has a rapid COVID-19 test and then a regular COVID-19 test on the same day, would that be covered?

Yes. Because they're different types of COVID-19 tests, each will be covered.

If a COVID-19 test is administered in an outpatient setting prior to an admission, is the test considered bundled/inclusive?

Click here for claims submission guidance for COVID-19 testing for preadmission services.

What about testing for the flu vs. testing for COVID-19? Will both tests be allowed on the same date of service?

Both tests will be allowed on the same date of service. Additionally, there are lab tests that are combined to test for both the flu and COVID-19. Those will be covered under our cost-share waiver for testing.

Will Blue Cross NC cover the new CPT code for SARS-CoV-2 + Flu?

Yes.

Can you clarify when to use the Z codes and when to use the -CS modifier?

Visit our coding guidance page for more details.

For the new CPT codes for SARS-CoV-2 + Flu, will they be covered and when will we be able to bill for this?

Blue Cross NC will cover the SARS-CoV-2 + Flu (0240U and 0241U). Providers should hold these claims until Dec. 15, 2020.

When will we be allowed to bill the COVID-19+flu test? We were told we could bill after Dec. 15, 2020, but it's still not on the fee schedule.

You are currently able to bill for SARS-CoV-2 + Flu (0240U and 0241U). Even if it's not on the fee schedule, you may still bill for this.

Should we use Z20.822 as the primary diagnosis on the flu test and other in-house labs when seeing patients with COVID-19 + flu symptoms?

With the diagnosis codes, you should have Z20.822 on every claim line associated with a service performed in conjunction with the decision leading up to the actual COVID-19 test. If the flu test was done during a visit to determine if the COVID-19 test was needed, you should use Z20.822 as noted.

The CDC now says quarantine can be shortened for asymptomatic contacts to seven days with a negative COVID-19 test within the last 48 hours. How do we bill for that?

Providers should follow the same guidance as listed on our coding guidance page for COVID-19 testing.

Is Blue Cross NC covering COVID-19 screening prior to holiday gatherings?

Blue Cross NC announced a new temporary measure for COVID-19 screening prior to end-of-the-year holiday gatherings on Nov. 17. Click here for more details.

AHIMA and AHA advised not to assign Z11.52 at all until the pandemic is declared officially over. Why is Blue Cross NC advising us to use this code?

While it has been recommended that this code not be used until after the pandemic, Blue Cross NC understands that there may be some providers who do not have access to those guidelines. Our primary concern is ensuring members who qualify for the cost-share waiver receive it. This is why we are allowing for this code to be used for dates of service on or after Feb. 1, 2021, to indicate clinical visits to determine if testing is needed.

COVID-19 Vaccines

Where can I get more information on Blue Cross NC's coverage for COVID-19 vaccines?

Click here to find details, including coding/claims guidelines and a provider FAQ.

Are there any special modifier or diagnosis requirements/comments required for COVID-19 vaccine claims? Are we to submit the charge for the vaccine administration on a claim by itself or must it also have the vaccine code accompanied by a $0 charge since the government is covering the vaccine cost?

There are no special modifiers or diagnosis requirements for COVID-19 vaccine claims. While this is different from CPT requirements for other vaccines, we are allowing the administration code to be submitted on its own for FDA-authorized COVID-19 vaccines. If your system is set up so that you're auto-billing vaccines with the administration on the same claim, you can bill the vaccine itself accompanied by a $0 or 1% charge (based on your clearinghouse) and then bill the administration code on same claim.