

**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.

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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.

You said you would reevaluate the deadlines for all these measures as the pandemic evolves. Have you done that?

Yes, please see this [Provider News update from May 4, 2020](#), for the latest deadlines for these measures.

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 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-10 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.

What code should/could we use for billing personal protective equipment (PPE) above and beyond what our practice would usually use? For example, how would we code if we are a pediatric practice and needed to see a child in full PPE due to suspected COVID? Can we use 99070? If so, should we use a modifier?

Blue Cross NC does not pay separately for PPE, as this would be included in any services billed by the provider.

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](#).

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. 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 with a goal to provide the difference in reimbursement by the end of the month.

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. 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.

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 on 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
<p>Patient is a Blue Cross NC member but is receiving care outside of North Carolina (i.e. Inter-Plan Program/IPP Home).</p> <p>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 in Texas.</p>	<p>Blue Cross NC's member benefits and related cost-sharing would apply.</p> <p>In the example, the normal cost-sharing (copays, deductibles, coinsurance) dictated by the patient's Blue Cross NC commercial benefits would apply.</p>	<p>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.</p> <p>In the example, BlueCross BlueShield of Texas reimbursement policy would apply.</p>
<p>Patient is a member of another local Blue Cross and Blue Shield plan but is receiving care in North Carolina (i.e. IPP Host).</p> <p>Example: Patient is a member of BlueCross BlueShield of Texas but is currently</p>	<p>The patient's home plan benefits apply.</p> <p>In the example scenario, BlueCross BlueShield of Texas member benefits apply.</p>	<p>The host plan's reimbursement policy applies. The provider should contact the plan where they practice for reimbursement information.</p> <p>In the example scenario, BlueCross NC reimbursement policy applies, but BCBS TX benefits could override our payment policy.</p>

<p>living in North Carolina. The patient has a physical therapy telehealth visit with a PT provider practicing in North Carolina.</p>		
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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?

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 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. It should not be used when billing 99441-99443.

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 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 coinsurance for 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.

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.

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.

Is the early refill option available to all prescriptions?

The early refill measure applies to all medications, and 90-day prescriptions are encouraged for the drugs that are eligible (typically maintenance medications for treating ongoing conditions). State and federal laws, formulary and quantity limits, and prior authorizations regarding prescriptions will still apply.

Why are we encouraging 90-day supply but only allowing payment for 60 days?

The member's pharmacy specific benefit determines the amount of medication that a member can receive. While we encourage 90-day supplies when possible, some group plans may only allow for a 30-day supply at a time. Hence, why a 60-day supply (a one-month refill plus one), would be allowed instead of a 90-day supply. Traditional maintenance medications typically will have no issue being refilled for a 90-day supply.

The documentation states we have waived early medication refill limits on prescriptions. Are there any provisions on situations where the doctor's office is not open during normal hours (closed due to NC COVID-19 and a refill is needed for a maintenance prescription, with no refills left on the current prescription).

In the event a pharmacist or device and medical equipment permit holder receives a request for a prescription refill and the pharmacist or permit holder is unable to readily obtain refill authorization from the prescriber because of the prescriber's inability to provide medical services to the patient, the pharmacist or permit holder may dispense a onetime emergency supply of up to 90 days of the prescribed medication, provided that:

1. The prescription is not for a Schedule II controlled substance;
2. The medication is essential to the maintenance of life or to the continuation of therapy in a chronic condition;
3. In the pharmacist's or permit holder's professional judgment, the interruption of therapy might reasonably produce undesirable health consequences;
4. The dispensing pharmacist or permit holder creates a written order entered in the pharmacy's automated data processing system containing all of the prescription information required by Section .2300 of these Rules and signs that order; and
5. The dispensing pharmacist or permit holder notifies, or makes a good faith attempt to notify, the prescriber or the prescriber's office of the emergency dispensing within 72 hours after such dispensing.

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 was from April 9, 2020 through April 23, 2020. We have extended this measure, and the new expiration date is May 31, 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 and Related Visits

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 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 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 kits 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.

Do you have coding guidance for obtaining a specimen for COVID-19 testing in the provider’s office? What if the visit is for specimen collection only and not tied to any other service?

We don’t provide reimbursement for specimen collection. However, the provider can bill for the office visit based on the level of care provided.

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.

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 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 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.