Updated: August 4, 2020

# Cost-sharing, coding and billing

## Blue Shield of California and Blue Shield of California Promise Health Plan Providers

At Blue Shield of California and Blue Shield of California Promise Health Plan, we continue to do all we can during the COVID-19 public health emergency to support the health, safety and well-being of our members. We also want to keep you informed as you courageously continue to provide care on the front lines during the COVID-19 pandemic.

Please check this section periodically to stay informed. We will update the content periodically by replacing this document with a new date.

## Prior Authorization for COVID-19 screening and testing and treatment

There is no prior authorization required for COVID-19 screening, testing and treatment.

## Member cost-sharing waivers for treatment extended through December 31, 2020

Through **December 31, 2020**, Blue Shield will continue waiving copayments, coinsurance, and deductible requirements for COVID-19 **treatment** for members who are covered under fully insured commercial HMO and PPO plans and Medicare Advantage plans.

The cost-sharing waivers for treatment also apply to members enrolled in self-funded and flex-funded plans administered by Blue Shield if the plan sponsor has elected to participate in the waiver.

Members in self-funded plans have ID cards that state Blue Shield provides "Administrative Services Only." Please check with us to determine whether the member's cost-sharing is waived for COVID-19 treatment.

Cost-sharing for medical services is not applicable to Medi-Cal and Cal MediConnect plans.

**For specific information on coding and billing for screening and testing, please review the information below.**

## Member cost-sharing for screening and testing waivers throughout COVID-19 public health emergency

Blue Shield continues to waive member cost-sharing for diagnostic COVID-19 **screening and testing.** In accordance with applicable state and federal laws, we will continue to waive these costs throughout the declared COVID-19 public health emergency. This includes waiving cost-sharing for diagnostic testing and related screening services provided to individuals with symptoms or known or suspected exposure to COVID-19. For self-funded and flex-funded plan members, please check eligibility for these cost-sharing waivers, as they are based on plan sponsors' decisions.

**For specific information on coding and billing for screening and testing, please review the information below.**

## Coding and billing for COVID-19 treatment you provide to your patients

When submitting claims for treatment provided to a member who has been diagnosed with COVID-19, please identify COVID-19 specifically on the claim. **The diagnosis code U07.1 will be the only diagnosis code recognized for the treatment of COVID 19 on a member's claim in order to apply the waiver of applicable copayments, coinsurance or deductibles.**

## Coding and billing for COVID-19 specimen collection for diagnostic testing

CMS has issued specimen collection codes for laboratories billing for COVID 19 testing. Clinical laboratories are to use these codes to identify and reimburse for specimen collection. These codes are effective on March 1, 2020. Healthcare providers who are **only performing the collection of the patient specimen for testing of COVID-19** should bill one of the following CPT or HCPCS codes:

- **HCPCS code G2023**: Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source
- **HCPCS code G2024:** Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source
- **When billing CPT code 99001** the provider will need to bill with one of the diagnosis codes defined by the CDC, along with the 99001 code described below:

  CPT 99001: Handling and/or conveyance of specimen for transfer from the patient in other than an office to a laboratory

A list of DX codes defined by the CDC that are acceptable to submit along with the CPT 99001 is available https://www.cdc.gov/nchs/Guidelines provided by Centers for Medicare & Medicaid Services (CMS) are also recognized for commercial coverage, as well.

## Coding and billing for COVID-19 diagnostic screening visit

**COVID-19 screening by a healthcare professional is done to determine whether diagnostic testing is recommended.**

- The Centers for Disease Control has developed a new ICD10-CM diagnosis, U07.1-COVID-19. This diagnosis code is specific to COVID-19.
- There has been a change to the CDC ICD10 Official Coding and Reporting Guidelines from February 20, 2020 publication. **Blue Shield made the following ICD 10 diagnostic screening changes effective with claims for dates of service effective on and after June 1, 2020.**
    - **Addition of ICD 10 Diagnosis code Z11.59 "encounter for screening for other viral diseases"**

  Please note: Blue Shield has made a business decision to adopt the diagnosis code **U07.1** in our claims system with an effective date of **February 4, 2020** (meaning for dates of service on and after **February 4, 2020**).

  This decision applies ONLY to those plans for which Blue Shield is the primary payor.

  Blue Shield will be accepting (for diagnoses) EITHER the CDC diagnosis coding available at https://www.cdc.gov/nchs OR the new ICD-10 Code U07.1 described above.

## Coding and billing for COVID-19 diagnostic testing

Diagnostic testing for COVID-19 is done AFTER the patient is screened by a health care professional who determines testing is recommended. Here are HCPCS codes for healthcare providers who **test** patients for COVID-19:

- **HCPCS code U0001:** Providers using the Centers for Disease Control and Prevention (CDC) 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel may bill for that test using this newly created HCPCS code (U0001).
- **HCPCS code U0002**: The second new HCPCS code (U0002) can be used by laboratories and healthcare facilities to bill Medicare as well as by other health insurers that choose to adopt this new code for such tests. HCPCS code U0002 generally describes 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19) using any technique, multiple types or subtypes (includes all targets).
- **CPT code (87635):** American Medical Association (AMA) released this new CPT code to use for testing and billing for COVID-19.

Blue Shield is offering coverage for these codes effective for dates of service on and after **February 4, 2020** for Blue Shield and Blue Shield Promise members. This is a business decision made by Blue Shield for Blue Shield and Blue Shield Promise members.

## Coding and billing for HCPCS codes for COVID 19 High Throughput Technologies

**Providers must meet the following requirements in order to bill using U0003 and U0004 for high throughput testing:**

- **Effective date: March 18, 2020, continuing throughout the COVID-19 public health emergency.**
- Own/operate a high throughput machine. This is highly sophisticated equipment which requires intensive technician training and is a more intensive testing process than the processes applicable to U0001 & U0002 or 87635.

- **U0003**: Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R.

- **U0004**: 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R.

# Coding and billing for professional services provided via telehealth

### Medical Services via telehealth

For services provided to Blue Shield commercial plan members, professional providers should bill for sessions that do not require hands-on care by indicating the appropriate CPT / HCPCS code for the service(s) they provided. This may include the use of evaluation and management (E&M) codes, telehealth or telephone services. We ask that you continue documenting the services provided and indicating "02" for place of service.

Professional providers should include modifiers 95 for synchronous rendering of services or GQ for asynchronous when billing for services provided via telehealth and the place of service should be indicated as "02."

Professional providers of medical services via telehealth for Blue Shield Promise Medicare Advantage, Cal MediConnect and Medi-Cal members should consult with the member's participating provider group or management service organization regarding the codes to use for care provided via telehealth.

## Medical Services via telehealth, cont'd.

### Medicare

For services provided to Blue Shield and Blue Shield Promise Medicare plan members and billed directly to Blue Shield or Blue Shield Promise, professional providers should bill for sessions that do not require hands-on care by indicating the appropriate CPT / HCPCS code for the service(s) they provided. This may include the use of evaluation and management (E&M) codes, telehealth or telephone services.

Throughout the COVID-19 public health emergency, please apply the following information to telehealth claims submitted for Medicare members:

- Place of Service (POS) equal to what it would have been had the service been rendered "in person."
- Modifier 95, indicating that the service that was rendered was actually performed via telehealth.

Please visit the online resources listed below for additional information and guidance for federally qualified health centers (FQHCs) and rural health clinics (RHCs) online:

- April 3, 2020: MLN Connects Special Edition: COVID-19
- April 30, 2020: MLN SE20016.

### Medi-Cal

For services provided to Blue Shield Promise Medi-Cal plan members and billed directly to Blue Shield Promise, professional providers should bill for sessions that do not require hands-on care by indicating the appropriate CPT / HCPCS code for the service(s) they provided. This may include the use of evaluation and management (E&M) codes, telehealth or telephone services.

Throughout the COVID-19 public health emergency, please apply the following information to claims submitted for the Medi-Cal members :

- Place of Service "02" to designate telehealth.
- Modifier 95 for synchronous rendering of services or GQ for asynchronous

Please visit the DHCS website for additional information and guidance for FQHCs, RHCs, and Tribal 638 clinics.

We also ask providers who bill for Medi-Cal members to reference the Department of Healthcare Services' Medi-Cal Provider Manual: http://www.medi-cal.ca.gov/default.asp.

# Coding and billing for professional services provided via telehealth, cont'd.

## Behavioral health services via telehealth

**Appending a modifier to the CPT/HCPCS codes when billing for professional behavioral health services provided to members via telehealth**

Professional providers should include modifiers 95 for synchronous rendering of services or GQ for asynchronous when they are billing for services provided via telehealth. The place of service is indicated as "02." for commercial members. (See above Medicare Advantage and Medi-Cal section)

## Ancillary Services via telehealth

**Coding for professional ancillary care telehealth visits**

For services provided to members, professional and ancillary providers may bill for sessions that do not require hands-on care by indicating the appropriate CPT / HCPCS code for the service(s) they provided. This may include the use of evaluation and management (E&M) codes, telehealth or telephone services. Please continue documenting the services provided and indicating "02" for place of service. , for commercial members. (See above Medicare Advantage and Medi-Cal section)

**Appending a modifier to the CPT/HCPCS codes when billing for ancillary non-hands-on services provided to members via telehealth**

Professional ancillary providers should include modifiers 95 for synchronous rendering of services or GQ for asynchronous when billing for services provided via telehealth and the place of service is indicated is "02."

**Billing for physical therapy and occupational therapy provided via telehalth that is not hands-on therapy.**

Practitioners who are contracted with Blue Shield should use the same billing codes for all professional and ancillary services described above for non-hands-on services, using the correct CPT codes, clearly documenting the services provided, and indicating an "02" for place of service and modifiers 95 for synchronous rendering of services or GQ for asynchronous when billing for services provided via telehealth . for commercial members. (See above Medicare Advantage and Medi-Cal section)

**Billing for physical therapy and occupational therapy provided via telehealth that is not hands-on therapy, cont'd.**

Physical therapy (PT), occupational therapy (OT), speech therapy (SP), and registered nurse dietitian nutritionist services can all be provided via telehealth, limited to services that are not "hands-on" and can be provide remotely.

Examples of common CPT codes that fall into this category: PT – 97110, OT – 97530, SP – 92507
Guidelines for ancillary services that can be offered remotely are also available from the CPT 2020 Professional Edition published by the American Medical Association: CPT 2020 Professional Edition, AMA, Chicago 2020, page 40.

**Billing for attending physician services to members in inpatient settings via telehealth or telephone**

We ask that providers document and bill for the services provided and use the correct E&M code or inpatient telehealth procedure codes, if applicable.

## Frequently asked questions

**Are E&M codes for telehealth services for a new patient different from an established patient?**

Providers should use the same E&M codes you currently use to bill for new patients versus established patients. As always, be certain to indicate the place of service as "02".

**Whom should I bill for services provided via telehealth during the COVID-19 public health emergency?**

For services provided to Blue Shield commercial HMO and Medicare Advantage HMO members, network IPA/medical groups are responsible for treatment costs.

Fee-for-service providers should bill in the same way they normally do by directing their payments to the appropriate payor.

T10979 (8/20)

Y0118_20_546A_C 08072020 (approval for cost-sharing information update)