

Updated: April 15, 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 provide care on the front lines.

Please check this section frequently to stay informed. We will update the content as new information becomes available by replacing this document and changing the date.

Prior Authorization for COVID-19 treatment

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

Member cost-sharing for screening, testing and treatment

Blue Shield and Blue Shield Promise are waiving all member copayments, coinsurance and deductibles applicable to COVID-19 **screening, testing and medical treatment for members diagnosed with COVID-19**. This applies to all fully-insured commercial plan HMO and PPO plan members, and Medicare Advantage members. This includes screening, testing and treatment provided at hospitals, urgent care facilities, emergency rooms, physician offices and other designated locations.

Copayments, coinsurance and deductibles do not apply to Cal MediConnect and Medi-Cal members.

Member cost-sharing for screening, testing and treatment, cont'd.

Blue Shield will assume risk for the waived member cost-sharing administered by providers for COVID-19 screening, testing and treatment provided to Blue Shield and Blue Shield Promise members

- For capitated commercial business, Blue Shield will absorb the costs for waived member copayments, coinsurance, and deductibles applicable to COVID-19 screening, testing, and treatment. For employer groups with an HMO Flex Funded plan that have chosen to “opt-in” to the waiver of cost sharing for COVID-19 treatment, the plan sponsor will be responsible for the cost.
- For capitated Medicare Advantage business, Blue Shield and Blue Shield Promise will absorb the costs for waived member copayments, coinsurance, and deductibles applicable to COVID-19 screening, testing, and treatment.
- Payments will be provided to capitated providers to cover copayments, coinsurance, and deductibles as a result of the waiver. This includes facilities and Medical Groups administering screening, testing, and treatment on HMO products across Blue Shield and Blue Shield Promise Health Plans. Providers will be expected to participate in submitting these cases to assist in validating reimbursement payments.
- Copayments are not applicable to Medi-Cal or Cal MediConnect members.

Members whose coverage is under a Blue Shield self-funded employer plan

For Blue Shield members enrolled in self-funded plans, the same cost sharing waivers will apply for COVID-19 testing and screening. However, self-funded plans may choose whether to waive cost-sharing for COVID-19 treatment. Please verify with Blue Shield whether cost sharing waivers apply for a member whose coverage is through a self-funded plan.

If a member's plan ID card indicates “**Administrative Services Only,**” the member's plan is self-funded.

Coding and billing for COVID-19 screening

COVID-19 screening is performed by a healthcare professional to determine whether 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 are [interim ICD-10-CM official coding guidelines](#), effective February 20, 2020.

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 testing

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 need to **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.

CMS developed two new 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.

Coding and billing for COVID-19 testing, cont'd.

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 CPT99001 is available <https://www.cdc.gov/nchs/>

[Guidelines](#) provided by Centers for Medicare & Medicaid Services (CMS) are also recognized for commercial coverage, as well.

Blue Shield is offering coverage for these testing 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 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 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.

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.

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."

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. We ask that they continue documenting the services provided and indicating "02" for place of service.

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

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 is indicated as "02."

Billing for physical therapy and occupational therapy provided via telehealth 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.

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.

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