January 20, 2021

Cost-sharing, coding, and billing for COVID-19 testing

Blue Shield of California HMO and PPO commercial plans

At Blue Shield of California (Blue Shield), we will continue to do all we can to support the health, safety, and well-being of our members, especially during this COVID-19 pandemic. 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 of the website often to stay informed. As changes in laws and mandates and business decisions occur, we will update this content to reflect the latest information. We will also continue to add announcements on the home page of our COVID-19 provider website.

Prior authorization for COVID-19 diagnostic testing

There is no prior authorization required from Blue Shield for COVID-19 diagnostic testing. However, asymptomatic essential workers need to contact Blue Shield to receive instructions on how to locate an in-network provider for testing before arranging their testing appointment.

Member cost-sharing waivers for COVID-19 diagnostic testing

In accordance with applicable state and federal laws throughout the COVID-19 public health emergency, as well as Blue Shield business decisions, we will continue to waive member cost-sharing for symptomatic patients, for patients with known or suspected exposure, and for patients who will undergo a medically necessary surgery or medical procedure that requires a preliminary COVID-19 test. This cost-sharing waiver is available for diagnostic testing ordered by a member's attending healthcare provider based on an individualized clinical evaluation to determine whether the test is medically appropriate for the patient in accordance with current accepted standards of medical practice.

This cost-sharing waiver applies to all commercial HMO, POS, PPO, and EPO plan members who have Blue Shield coverage under any individual and family, small group, and large group plans, including self-funded plans.

Financial responsibility of delegated providers

- In accordance with the Department of Managed Health Care (DMHC) emergency regulation published July 17, 2020, Blue Shield will retain financial responsibility for COVID-19 **diagnostic** and **asymptomatic essential worker testing**. **All providers and labs should bill Blue Shield directly for specimen collection, handling, and testing processes for these tests. This applies to Blue Shield commercial HMO members.**

- This will remain in effect throughout the effective period of the DMHC emergency regulation referenced above. Once that period ends, the delegated providers will resume responsibility for COVID-19 diagnostic testing, including specimen collection, handling, and testing services, in accordance with the terms of their existing provider agreements with Blue Shield.

- COVID-19 testing that falls outside of the scope of the DMHC emergency regulation, including but not limited to **antibody and asymptomatic non-essential worker screening[1] testing**, will remain the responsibility of the delegated provider, in accordance with their provider agreement with Blue Shield.

For specific information on Blue Shield's **preferred coding and billing for screening tests and diagnostic tests**, please review the detailed information below.

Please especially note the sections pertaining to essential worker* testing and the member cost-sharing that applies in some cases in accordance with the DMHC mandate published July 17, 2020.

[1]**A COVID-19 screening test** is used for an **asymptomatic patient** with no reason to suspect infection (e.g., no known or suspected exposure) to determine whether the patient is infected with COVID-19. This might include, for example, testing for employment purposes or for purposes of travel.

*All references to essential workers in this document are in accordance with the definition used by the DMHC.

Definitions and Guidelines

COVID-19 evaluation versus COVID-19 screening test

At Blue Shield, we have noticed that the terms "COVID-19 evaluation" and "COVID-19 screening" have sometimes been used interchangeably. We would like to clarify the differences that appear in this document, to avoid confusion.

- **A COVID-19 evaluation** by a healthcare professional via a telehealth visit or an in-person visit is needed to determine whether diagnostic testing is recommended for the patient.

- **A COVID-19 screening test** is used for an **asymptomatic patient** to determine whether the patient is infected with COVID-19.

COVID-19 screening test versus COVID-19 diagnostic test

There has been confusion in the provider community about what is considered a "screening test" versus a "diagnostic test." For clarification, please review these descriptions:

- **COVID-19 screening test:** A test performed on an asymptomatic patient to assess whether the patient is infected with COVID-19, with no specific reason for thinking the patient may be infected (such as suspected exposure).

- **COVID-19 diagnostic test:** A test that is ordered by a physician, pharmacist, or other licensed healthcare provider within their scope of practice who has determined a test is medically necessary due to specific qualifying reasons detailed in the following pages.

Coding and billing for these services

- It is important to note that **specimen collection codes are inclusive to the office visit codes and are not billable in addition to an office visit.**

- In addition, **a screening test is coded and billed differently from a diagnostic test.** Blue Shield has created policies in accordance with federal and state laws regarding COVID-19 service requirements for member cost-sharing (member financial responsibility) for screening testing and diagnostic testing, especially in regard to the July 17, 2020 DMHC mandate related to testing for **essential workers**.

- **In the following pages of this document, the provided coding and billing preferences are intended to help you submit claims to be processed as accurately and quickly as possible. These recommendations are not intended to be an all-inclusive list.**

*All references to essential workers in this document are in accordance with the definition used by the DMHC.

Coding and billing: Specimen collection for COVID-19 testing

Benefit for eligible members

In accordance with Blue Shield's preferences, to ensure efficient and accurate claims processing, healthcare providers who are only performing the collection of the patient specimen for COVID-19 screening testing or diagnostic testing should bill using one of the following CPT or HCPCS codes:

- **HCPCS code G2023**: Specimen collection for COVID-19 [severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)], any specimen source. Please note that this is the most widely used code.
- **HCPCS code G2024:** Specimen collection for COVID-19 from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source.
- **C9803 code:** Hospital outpatient clinic visit specimen collection for COVID-19, any specimen source.
- **CPT code 99001**: Handling and/or conveyance of a specimen for transfer from the patient in a setting other than an office to a laboratory.
    - This code will not be reimbursed when it is billed with an office visit or specimen collection code.
    - Please note that use of a specimen collection code instead of CPT 99001 will expedite and maximize proper reimbursement.
- **CPT code 99072:** Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency, as defined by law, due to respiratory-transmitted infectious disease. This code will be considered for reimbursement when it is billed for services defined by the American Medical Association's CPT code description and when an office visit results in diagnostic testing for COVID-19, throughout the duration of the declared federal and/or state COVID-19 public health emergency.

*All references to essential workers in this document are in accordance with the definition used by the DMHC.

Coding and billing: COVID-19 testing by category

Benefit for eligible members: **Asymptomatic** self-identified **essential worker* screening** test

How the patient may present and request a test

- No provider order is needed for an **asymptomatic self-identified essential worker screening test**; however, the asymptomatic essential worker must contact Blue Shield to ask for direction to an in-network provider before making their appointment for a screening test.
- It is the responsibility of Blue Shield to ensure that an appointment for testing is made available to these members within 48 hours of the request and within 15 miles or 30 minutes of either the individual's home or workplace.
- If an in-network provider appointment is not available in accordance with that criteria, the member can seek testing at any site in or outside of the network.
- Workers will need to attest to the provider that they are an essential worker as specified on the DMHC's website defining essential worker.
- Further information for members and test site locations are posted on Blue Shield's COVID-19 member website.

Coding and billing for a COVID-19 screening test for an asymptomatic essential worker

- To identify that the screening test is for an asymptomatic essential worker, the specimen collection provider should write on the lab order the diagnosis code Z02.79: Encounter for issue of another medical certificate.
- The lab receiving the COVID testing specimen for the asymptomatic essential worker should submit a claim for the test using the -32 modifier (e.g., 87635-32) and diagnosis code Z02.79.
- Rapid, point-of-care antigen testing done onsite should also use the -32 modifier (e.g., 87426-32) and with the diagnosis code Z02.79.
- Do not use Z11.59 which indicates encounter for screening for other viral diseases.

NOTE: The -32 modifier signifies mandated services according to the DMHC regulation published July 17, 2020. Use of the -32 modifier is needed to differentiate an asymptomatic essential worker test from an asymptomatic non-essential worker test because asymptomatic non-essential worker screening is not a covered benefit.

Member financial responsibility for this type of test

- Asymptomatic essential worker screening tests are covered only for members enrolled in fully insured commercial plans (individual and family, small group, and large group). Members who receive asymptomatic essential worker screening tests are responsible for copayments, coinsurance, and deductibles when receiving these tests.

- Asymptomatic testing (for essential workers* or other enrollees) generally is not covered for self-funded plans [administrative services only (ASO) plans], Medicare, Medi-Cal, or Cal MediConnect plans, except as outlined below under **COVID-19 diagnostic testing when known or suspected exposure has occurred** and **Pre-procedural COVID-19 diagnostic testing**.

Delegated provider financial responsibility for this type of test

- In accordance with the DMHC emergency regulation published July 17, 2020, Blue Shield will retain financial responsibility for coverage of **all COVID-19 asymptomatic essential worker testing**. All delegated providers and labs should bill Blue Shield directly for specimen collection, handling, and testing processes for these tests for Blue Shield commercial HMO members.

*All references to essential workers in this document are in accordance with the definition used by the DMHC.

Coding and billing: COVID-19 testing by category, cont'd.

Benefit for eligible members: **Symptomatic diagnostic** testing for all commercial HMO and PPO members (including self-identified essential workers*)

How the patient may present and request a test

Any member (including any self-identified essential worker) who presents with symptoms that they suspect may be related to COVID-19 needs a qualified clinician's order for a COVID-19 diagnostic test. Please see the above information for requirements pertaining to screening tests for self-identified essential workers without a qualified clinician's order.

- We recommend that these members call their regular provider for an evaluation, so the physician or other qualified clinician can determine whether it is medically necessary, according to accepted standards of medical practice, to order a diagnostic test. This would be determined by conducting an individual evaluation.

- The clinician would then collect the specimen onsite or refer the member to an appropriate facility to have a specimen collected. We recommend that specimen collection and testing be done at in-network facilities to avoid member costs related to provider balance billing.

Billing and coding for symptomatic diagnostic tests

The CPT codes listed below are appropriate for members who are **symptomatic** and who have an order from a qualified clinician.

CPT Code	Description		CPT Code	Description
J02.9	Acute pharyngitis, unspecified		J98.9	Respiratory disorder, unspecified
J06.9	Acute upper respiratory infection, unspecified		R05	Cough
J12.81	Pneumonia due to SARS-associated coronavirus		R06.00	Dyspnea, unspecified
J12.89	Other viral pneumonia		R06.02	Shortness of breath
J12.9	Viral pneumonia, unspecified		R06.03	Acute respiratory distress
J22	Unspecified acute lower respiratory infection		R50.9	Fever, unspecified
J80	Acute respiratory syndrome			

- For symptomatic patient testing, use diagnostic test codes **without** the -32 modifier: 87635 (PCR/LAMP) or 87426 (antigen, rapid).
- Symptomatic testing requires a valid provider order (medically necessary based on an individual evaluation according to accepted standards of medical practice) and should have a diagnostic code consistent with the presenting symptoms suggestive of a COVID-19 infection.

Member cost-sharing responsibility for this type of test

The member is **not** responsible for the copayment, coinsurance, or deductible associated with this reason for a COVID-19 diagnostic test. Eligible members include all commercial HMO and PPO plan members: individual and family, small group, and large group, including self-funded plans.

Delegated provider financial responsibility for this type of test

In accordance with the DMHC emergency regulation published July 17, 2020, Blue Shield will retain financial responsibility for **all COVID-19 diagnostic testing**. All delegated providers and labs should bill Blue Shield directly for specimen collection, handling, and testing processes for these tests for Blue Shield commercial HMO members.

*All references to essential workers in this document are in accordance with the definition used by the DMHC.

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

Benefit for eligible members: COVID-19 **diagnostic testing** due to **known or suspected exposure**

How the patient may present and request a test

Any member (including any self-identified essential worker) who presents with known or suspected exposure to COVID-19 needs a qualified clinician's order for a COVID-19 diagnostic test. See the information above for requirements pertaining to screening tests for self-identified essential workers without a qualified clinician's order.

- We recommend that these members call their regular provider for an evaluation, so the physician or other qualified clinician can determine whether it is medically necessary, according to accepted standards of medical practice, to order a diagnostic test. This would be determined by conducting an individual evaluation.
- The clinician would then collect the specimen onsite or refer the member to an appropriate facility to have a specimen collected. We recommend that specimen collection and testing be done at in-network facilities to avoid member costs related to provider balance billing.

Billing and coding for COVID-19 diagnostic tests

- Use diagnosis code **Z20.828**: Contact with and (suspected) exposure to other viral communicable diseases.
- Use diagnostic test codes **without** the -32 modifier: 87635 (PCR/LAMP) or 87426 (antigen, rapid).

The following codes should not be used for this type of diagnostic testing, as they indicate that diagnostic testing has already ruled out COVID-19:

- **Range Z03**: Encounter for medical observation for suspected diseases and conditions ruled out
- **Z03.818**: Encounter for observation for suspected exposure to other biological agents ruled out
- **Z03.89**: Encounter for observation for other suspected diseases and conditions ruled out

Member financial responsibility for this type of test

The member is **not** responsible for the copayment, coinsurance, or deductible associated with this reason for a COVID-19 diagnostic test. Eligible members include all commercial HMO and PPO plan members: individual and family, small group, and large group plans, including self-funded plans.

Delegated provider financial responsibility for this type of test

In accordance with the DMHC emergency regulation published July 17, 2020, Blue Shield will retain financial responsibility for **all COVID-19 diagnostic testing**. All delegated providers and labs should bill Blue Shield directly for specimen collection, handling, and testing processes for these tests for Blue Shield commercial HMO members.

*All references to essential workers in this document are in accordance with the definition used by the DMHC.

Coding and billing: COVID-19 testing by category, cont'd.

Benefit for eligible members: **Pre-procedural** COVID-19 diagnostic testing

When the member would need this test

- A member who is scheduled for a medically necessary surgery or other procedure requires a preliminary COVID-19 diagnostic test in order to protect the member, their healthcare providers, and other patients.
- This test requires a valid provider order**,** representing that it was medically necessary based on an individual evaluation according to accepted standards of medical practice.

Billing and coding for this COVID-19 diagnostic test

Use these codes for the COVID-19 diagnostic test conducted before a surgery or other procedure.

Code	Description
Z01.81	Encounter for preprocedural examinations
Z01.810	Encounter for preprocedural cardiovascular examination
Z01.811	Encounter for preprocedural respiratory examination
Z01.812	Encounter for preprocedural laboratory examination
Z01.818	Encounter for other preprocedural examination

Diagnostic test codes are 87635 or 87426 (**without** the -32 modifier).

Member financial responsibility for this type of test

The member is **not** responsible for the copayment, coinsurance, or deductible associated with this reason for a COVID-19 diagnostic test. Eligible members include all commercial HMO and PPO plan members: individual and family, small group, and large group plans, including self-funded plans.

Delegated provider financial responsibility for this type of test

In accordance with the DMHC emergency regulation published July 17, 2020, Blue Shield will retain financial responsibility for **all COVID-19 diagnostic testing**. All delegated providers and labs should bill Blue Shield directly for specimen collection, handling, and testing processes for these tests for Blue Shield commercial HMO members.

*All references to essential workers in this document are in accordance with the definition used by the DMHC.

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

Not a benefit: **Asymptomatic** COVID-19 screening testing (for **other than for essential workers*** enrolled in fully insured commercial plans)

How the member may present and request a test

An example of this type of screening testing is a work-related screening test for **non-essential** workers.

Billing and coding for this type of test:

- **Please do not submit a claim to Blue Shield for this type of testing. It is not a covered benefit.**
- The suggested diagnosis code for submitting this type of screening test to the lab, to help the lab separate this type of testing from others, is Z11.59 which indicates encounter for screening for other viral diseases.
- Screening test codes in this case would be 87635 (PCR/LAMP) or 87426 (antigen, rapid) without the -32 modifier used for essential worker testing.
- These test codes would not use the -32 modifier, because non-essential worker screening is not a mandated service.

Member financial responsibility for this type of test is 100%

- If an asymptomatic, non-essential worker makes it clear that they want a test, regardless of the fact that it would not be a covered benefit, they have taken all financial responsibility for getting the test.
- The FFCRA/CARES Act, as well as the DMHC mandate published July 17, 2020, do not mandate coverage of asymptomatic screening testing for members as a covered benefit, except for essential workers enrolled in fully insured commercial plans, as addressed above.

*All references to essential workers in this document are in accordance with the definition used by the DMHC.

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

May not be a covered benefit: **Antibody** (serology) testing

How the member may be eligible for this test as a covered benefit

- Most antibody testing is not done for diagnostic purposes and is not considered a covered benefit. Therefore, this is not a benefit in most situations, unless used for rare diagnostic purposes.
- This testing requires a valid provider order representing that it is medically necessary for diagnostic purposes based on an individual evaluation according to accepted standards of medical practice.
- In rare cases (such as MIS-C), a COVID-19 diagnostic antibody (serology) test may be conducted due to persistent symptoms suggesting a COVID-19 infection after a negative diagnostic test (PCR, LAMP, antigen) has already been conducted.

The persistent symptom would be used to show the need for using an antibody test to help make the diagnosis, using the applicable code, as in the table below for symptomatic patients:

CPT Code	Description		CPT Code	Description
J02.9	Acute pharyngitis, unspecified		J98.9	Respiratory disorder, unspecified
J06.9	Acute upper respiratory infection, unspecified		R05	Cough
J12.81	Pneumonia due to SARS-associated coronavirus		R06.00	Dyspnea, unspecified
J12.89	Other viral pneumonia		R06.02	Shortness of breath
J12.9	Viral pneumonia, unspecified		R06.03	Acute respiratory distress
J22	Unspecified acute lower respiratory infection		R50.9	Fever, unspecified
J80	Acute respiratory syndrome			

Billing and coding for this type of test code would be:

- 86769 for in-lab ELISA
- 86328 for lateral flow, rapid, point of care
- There is also a proprietary test code: PLA0224U that applies to only one test: an ELISA test for IgG (Mt. Sinai)

A claim for this must include a diagnostic code consistent with the presenting symptoms that are suggestive of an ongoing COVID-19 infection. It would not be a covered benefit for eligible members if it is not submitted with a diagnosis code noting ongoing symptoms and suggesting the need to use the test for diagnostic purposes.

The following codes should <u>not</u> be used when billing for this service, as they indicate prior testing has ruled out COVID-19:

- Range Z03: Encounter for medical observation for suspected diseases and conditions ruled out
- Z03.818: Encounter for observation for suspected exposure to other biological agents ruled out
- Z03.89: Encounter for observation for other suspected diseases and conditions ruled out

Member financial responsibility: No copayment, coinsurance, or deductible would apply to eligible members if it is evident that this type of test was conducted as a rare medical necessity for diagnostic purposes.

Coding and billing for other types of COVID-19 tests

Home test kits (specimen collections)

When a member uses a home specimen collection kit

Home test kits include instructions to patients for collecting swab or saliva specimens themselves, and a return mailer addressed to a lab that will process the test.

- This type of testing is covered when the appropriate category requirements are met, just as it would be for specimen collection by a provider.
- There are no actual home "tests" at this time, where a test of the specimen is processed in a patient's residence.
- For diagnostic testing based on symptoms, or known or suspected exposure, or for pre-procedural purposes, coverage requires a valid provider order representing that it is medically necessary based on individual evaluation according to accepted standards of medical practice.
- Home testing will soon be available for asymptomatic essential workers. When it becomes available for self-identified asymptomatic essential worker* testing, the home test kit will only be covered if the applicable criteria for essential worker testing outlined above is satisfied and will include, but not be limited to, the member contacting Blue Shield to identify and order the kit from the correct in-network home test kit provider.
- Once Blue Shield is able to make these kits become available for eligible members, the Blue Shield COVID-19 member website will direct asymptomatic essential workers to a network lab supplying home test kits and provide information on how to order and use them.

Billing and coding for this type of kit/test

- Use the appropriate codes to identify the reason for the testing and for the type of test. There are no special codes related to home testing kits.
- A claim should have a diagnostic code consistent with the reason for testing.
- Availability is currently limited by laboratories for this type of testing.

Member financial responsibility

If a patient is symptomatic, has known or suspected exposure, or is going to have a covered surgery or procedure, and has been given a clinician order for a COVID-19 diagnostic test, there is no copayment, coinsurance, or deductible under any of our plans.

Pooled testing

*All references to essential workers in this document are in accordance with the definition used by the DMHC.

At this time, pooled testing is at the sole discretion of the laboratory, is not widely being used, and is not available based by a provider's order or employer's request. When performed, it is billed, reported, and covered as though it is an individual test.

*All references to essential workers in this document are in accordance with the definition used by the DMHC.