

COVID-19: FAQs for Medicare Providers

May 08, 2020, updated Oct. 22, 2020

Our response to COVID-19 continues to evolve as we work to best serve our members and providers. Blue Cross and Blue Shield of Texas (BCBSTX) will continue to follow the applicable guidelines from [Texas Health and Human Services](#) and the [Centers for Medicare & Medicaid Services \(CMS\)](#) as appropriate for our members.

These FAQs refer to our Medicare members' access to care and other information during the Public Health Emergency, unless otherwise noted. Unless otherwise specifically described below, this information applies to our members in these individual and group Medicare (excluding Part D) and Medicare Supplement plans:

- Blue Cross Group Medicare Advantage (PPO)SM
- Blue Cross Group Medicare Advantage Open Access (PPO)SM
- Blue Cross Medicare Advantage (HMO)SM
- Blue Cross Medicare Advantage (PPO)SM
- Blue Cross Medicare Advantage Dual Care (HMO SNP)SM
- Blue Cross Medicare SupplementSM
- BlueStagesSM

Please visit our [Provider Information on COVID-19 Coverage](#) page and [News and Updates](#) for additional announcements.

1. [COVID-19 testing](#)
2. [COVID-19 treatment](#)
3. [Telemedicine](#)
4. [Pharmacy](#)
5. [More resources](#)

COVID-19 Testing for Medicare Members

Does BCBSTX cover the cost of testing for COVID-19 for Medicare members?

Yes. Medicare (excluding Part D) members won't pay copays, deductibles or coinsurance for lab tests to diagnose COVID-19. For Medicare Supplement members, these costs are covered by Original Medicare. Providers don't have to ask BCBSTX for approval to test for COVID-19. Testing must be for individualized diagnosis or treatment of COVID-19, medically appropriate and in accordance with generally accepted standards of care.

Does BCBSTX cover the cost of testing-related visits for COVID-19 for Medicare members?

Yes. Medicare (excluding Part D) and Medicare Supplement members won't pay copays, deductibles or coinsurance with in-network providers for testing-related visits related to COVID-19, including visits at a provider's office, urgent care clinic, emergency room and by telehealth. Medicare Supplement members do not have network restrictions unless otherwise noted by their plan terms.



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Which labs should I use for testing?

BCBSTX contracted providers are encouraged to use in-network labs that are equipped to provide testing. [Texas Health and Human Services](#) has information about labs and drive-through testing sites.

How should I code COVID-19 testing claims?

If you are collecting a COVID-19 sample from a member, submit the claim using the appropriate collection or lab code. Testing must be for individualized diagnosis or treatment of COVID-19, medically appropriate and in accordance with generally accepted standards of care, including the Centers for Disease Control (CDC) guidance as appropriate.

COVID-19 Collection Codes

- C9083 Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) any specimen source
- G2023 Specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), any specimen source
- G2024 Specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) from an individual in a SNF or by a laboratory on behalf of a HHA, any specimen source

COVID-19 Lab Codes

- 0202U Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR
- 0223U Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected
- 0225U Infectious disease (bacterial or viral respiratory tract infection) pathogen-specific DNA and RNA, 21 targets, including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), amplified probe technique, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected
- 0226U Surrogate viral neutralization test (sVNT), severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), ELISA, plasma, serum
- 0240U Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 3 targets (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B), upper respiratory specimen, each pathogen reported as detected or not detected
- 0241U Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 4 targets (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B, respiratory syncytial virus [RSV]), upper respiratory specimen, each pathogen reported as detected or not detected
- 87426 Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; severe acute respiratory syndrome coronavirus (e.g., SARS-CoV, SARS-CoV-2 [COVID-19])
- 87635 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
- 87636 Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) and influenza virus types A and B, multiplex amplified probe technique



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- 87637 Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), influenza virus types A and B, and respiratory syncytial virus, multiplex amplified probe technique
- 87811 Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])
- U0001 CDC 2019 Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel
- U0002 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC
- 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

See the [AMA website](#) and [Billing and Coding Guidance FAQs](#) on the CMS website for more information.

Does BCBSTX cover at-home tests?

We cover at-home collection methods for COVID-19 testing if the tests are authorized by the Food and Drug Administration (FDA), and are clinically indicated for the member. We encourage members to consult with their health care provider to determine whether the test is medically appropriate for their condition.

How should I code claims for COVID-19 antibody testing?

Submit claims for COVID-19 antibody testing to us using the appropriate code. Member cost-share will be waived during the public health emergency for antibody tests that are FDA-authorized, including tests with Emergency Use Authorization (EUA), regardless of the diagnosis. Antibody tests must be FDA-authorized, including EUA. Antibody testing should be medically appropriate for the member and ordered by a health care provider. Medical or invoice records may be requested to support if an antibody test is FDA-authorized or if EUA approval has been requested.

COVID-19 Antibody Testing Codes

- 0224U Antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)(Coronavirus disease [COVID-19]), includes titer(s), when performed
- 86318 Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single step method
- 86328 Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single step method, severe acute respiratory syndrome coronavirus (SARS-CoV-2) (Coronavirus disease COVID-19)
- 86408 Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); screen
- 86409 Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); titer
- 86413 Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) antibody, quantitative
- 86769 Severe Acute Respiratory Syndrome Coronavirus 2 [SARS-CoV-2] [Coronavirus disease [COVID-19]] testing via multiple-step method

How should I code claims for COVID-19 testing- and antibody-related services?

To indicate services performed in conjunction with the testing for COVID-19 or COVID-19 antibodies,



include one of the following diagnosis codes:

COVID-19 Diagnosis Codes

- U07.1 COVID-19
- B97.29 Other coronavirus as the cause of diseases classified elsewhere
- B34.2 Coronavirus infection, unspecified
- Z03.818 Encounter for observation for suspected exposure to other biological agents ruled out (possible exposure to COVID-19)
- Z20.828 Contact with and suspected exposure to other viral communicable diseases (actual exposure to COVID-19)

Modifier CS for testing-related services

Providers should use the CS modifier on applicable claim lines to identify the service as subject to the cost-sharing waiver for COVID-19. This is for testing-related services when COVID-19 testing or antibody testing must be performed at an alternate location and is not part of the evaluation and management claim.

How much will I be reimbursed for diagnostic testing?

We will follow CMS pricing and apply the applicable terms of our provider and/or network participation agreements.

- Out-of-network providers will be reimbursed according to CMS reimbursement rates.
- Note: For providers who negotiated a nonstandard reimbursement for labs as part of their participation agreement with BCBSTX, that contracted reimbursement rate may apply.

COVID-19 Treatment for Medicare Members

Does BCBSTX cover the cost of treatment for COVID-19 for Medicare members?

Yes. Medicare (excluding Part D) and Medicare Supplement members won't pay copays, deductibles or coinsurance for COVID-19 treatment with providers or at facilities. This change applies to costs associated with COVID-19 treatment from April 1 through Dec. 31, 2020 (previously Oct. 23, 2020).

Members should confirm whether their benefit plan covers services received from out-of-network providers. Medicare Supplement members do not have network restrictions unless otherwise noted by their plan terms. Members should call the number on their ID card for answers to specific benefit questions.

How should I check Medicare member benefits and eligibility?

Providers may use the [Availity® Provider Portal](#) or their preferred vendor to confirm member coverage and benefits.

- However, to verify telemedicine coverage, providers should call the number on the back of the member's ID card or Provider Services at 1-877-774-8592 for individual and 1-877-299-1008 for group and speak with a Customer Advocate. ([For more details on telemedicine.](#))

If a Medicare member is quarantined at home, will BCBSTX cover provider visits to the home?

Home visits, if available and offered, will be covered consistent with the member's medical benefits.

Is BCBSTX extending current prior authorizations for Medicare Advantage members?

Yes. BCBSTX is temporarily extending approvals on services with existing prior authorizations until Dec. 31, 2020, for Medicare Advantage members. This applies to services that were originally approved or



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scheduled between Jan. 1 and June 30, 2020. This is for most non-emergent, elective surgeries, procedures, therapies and home visits. See this [News and Updates article](#) for exclusions and more details.

A member may reschedule an approved procedure to a later date within 2020 without a new prior authorization. This applies to currently enrolled members for a benefit that is covered under their plan at the time services are rendered.

How does the Diagnosis Related Group (DRG) add-on payment apply to providers?

For discharges of members diagnosed with COVID-19, the weight of the assigned DRG has temporarily increased 20 percent. We will apply the temporary increase, as appropriate and where consistent with network contracts, for Medicare Advantage providers. Providers should use the appropriate diagnosis code and date of discharge to identify these members.

- B97.29 (Other coronavirus as the cause of diseases classified elsewhere) is for discharges occurring on or after January 27, 2020, and on or before March 31, 2020.
- U07.1 (COVID-19) is for discharges occurring on or after April 1, 2020, through the emergency period.

How is BCBSTX responding to the suspension of the Medicare sequestration?

The Medicare sequester has been suspended between May 1, 2020, and Dec. 31, 2020. During this time, BCBSTX is suspending the 2% sequestration reduction in Medicare claims payments. This applies to Medicare providers who service Medicare Advantage members.

How should a claim be rendered by a temporary provider, or “locum”?

Locum refers to physicians and advanced practice clinicians who fill in for other staff on a temporary basis. BCBSTX recognizes the efforts of temporary providers willing to help during the COVID-19 outbreak.

To expedite claims, these individuals – including medical doctor/midlevel retirees, affiliate and aligned providers and those with out-of-state licenses – should be billed using this process:

- All claims must include the rendering provider’s National Provider ID (NPI)
- Locum claims for medical doctors should be billed under one supervising medical doctor
 - Example: Locum claims for an MD should be billed under one name and rendering NPI# of the currently contracted MD for your taxID#
- Locum claims for midlevels (Advanced Practice Nurse (APN), Registered Nurse (RN) etc.) should be billed under one supervising midlevel
 - Example: Locum claims for midlevels should be billed under one name and rendering NPI# of the currently contracted midlevel for your taxID#
- All locum claims must contain a Q6 modifier at the claim line level

Due to COVID-19, will BCBSTX appeals procedures change?

We have temporarily adopted flexibilities in our appeals procedures to serve our Medicare members, in accordance with CMS guidance. If you have questions about claims or appeals, please contact the number on the back of the member’s ID card or Provider Services at 1-877-774-8592 for individual and 1-877-299-1008 for group and speak with a Customer Advocate.

Telemedicine for Medicare Members

Has BCBSTX expanded access to telemedicine at no cost-share for Medicare members?



Yes. Currently Medicare (excluding Part D) and Medicare Supplement members can access in-network telehealth services at no cost-share for medically necessary, covered services and treatments consistent with the terms of the member's benefit plan. Medicare Advantage PPO members have access to telehealth services with out-of-network providers but will be responsible for member cost-share for these services consistent with the terms of their plans.

Services available for telemedicine or telehealth may vary. Members should call the number on their ID card if they have questions.

This cost-share waiver for telemedicine services applies to claims beginning March 1, 2020, through Dec. 31, 2020. Starting Jan. 1, 2021, copays, deductibles and coinsurance will apply to telemedicine visits.

Which providers may provide telehealth services to Medicare members?

Providers of telemedicine may include, but are not necessarily limited to:

- Physicians
- Physician assistants
- Advanced Practice Registered Nurse (APRN)
- CMS-recognized, licensed behavioral health and applied behavioral analysis service providers
- Physical therapy, occupational therapy and speech therapy service providers

See CMS' [telehealth guidance](#) and [Waivers and Flexibilities](#) for more details.

How should I check Medicare members' benefits and eligibility for telemedicine?

- Call Provider Services to check eligibility and office visit benefits at 1-877-774-8592 for individual and 1-877-299-1008 for group. (Telemedicine is not yet a category offered in our automated Interactive Voice Response (IVR) phone system.)
- Verify general coverage by submitting an electronic 270 transaction. This step will help providers determine coverage information, network status, benefit prior authorization/pre- notification requirements and other important details.

Visit the CMS website for a [complete list of telehealth codes](#).

Can I provide telehealth services to new and established Medicare patients?

Yes. CMS currently is not requiring Medicare providers to have treated a patient in the previous three years to provide telehealth services. Providers can now engage in telehealth services with new Medicare patients.

Can I conduct Medicare members' annual health assessments by telemedicine?

Initial and subsequent Annual Wellness Visits (G0438 and G0439) may be conducted by telemedicine. Submit claims for wellness visits with Modifier 95 and Place of Service (POS) 11. BCBSTX covers one wellness visit every calendar year.

- Note: CMS has not approved Initial Preventive Physical Examinations (IPPE) (G0402) for telehealth. Members are eligible for the IPPE during their first 12 months of enrollment in Medicare.

Are prior authorizations required for telemedicine visits related to COVID-19?

Telemedicine visits for services related to COVID-19 are currently not subject to benefit prior authorization requirements. For services not related to COVID-19, existing authorization requirements would apply. If you have questions about prior authorizations, please use [Availity Authorizations & Referrals](#).



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How can telehealth/telemedicine be conducted for Medicare members?

Providers should use an interactive audio and video telecommunications system that permits real-time interactive communication to conduct telehealth services. CMS permits audio only in limited circumstances. See the CMS website for [designated audio-only codes](#).

Providers can find the latest guidance on acceptable Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant remote technologies issued by the [U.S. Department of Health and Human Services' Office for Civil Rights in Action](#).

How should I code telemedicine claims?

BCBSTX will reimburse providers for medically necessary services delivered via telemedicine and billed on claims with appropriate modifiers (95 and GT) in accordance with the member's benefits for covered services.

- Note: if a claim is submitted using place of service (POS) 02 or a telemedicine code, the modifier 95 is not necessary. Only codes that are not traditional telemedicine codes require the modifier.

Visit the CMS website for a [complete list of telehealth codes](#) and [telehealth guidance](#).

How will I be reimbursed for telemedicine claims?

Telemedicine claims for insured members submitted in accordance with appropriate coding guidelines, including appropriate modifiers, for in-network medically necessary covered health care services beginning March 1, 2020, will be covered without cost-sharing and will be reimbursed at the same rate as in-person office visits.

- Out-of-network providers: We reimburse out-of-network providers according to the CMS reimbursement rates. Please call the customer service number on the member's ID card for benefit information.

Pharmacy for Medicare Members

How is BCBSTX helping with prescriptions?

Members of these Medicare plans can get 90-day fills through mail order.

- Blue Cross Group Medicare Advantage (PPO)
- Blue Cross Group Medicare Advantage Open Access (PPO)
- Blue Cross Group MedicareRx (PDP)SM
- Blue Cross Medicare Advantage (HMO)
- Blue Cross Medicare Advantage (PPO)
- Blue Cross Medicare Advantage Dual Care (HMO SNP)

All pharmacy practice safety measures, as well as prescribing and dispensing laws, will remain in place.

More Resources

Continue to watch the [News and Updates](#) section of the BCBSTX website for updates. If you have additional questions, contact Blue Cross Medicare Advantage Network Management at 972-766-7100 or refer to the sources below.



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- CDC
- General: <https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page>
 - Fact Sheets and News Alerts: <https://www.cms.gov/newsroom>
 - Telehealth Services: <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>

 - General: <https://www.cdc.gov/nCoV>
 - Health Care Professionals: <https://www.cdc.gov/coronavirus/2019-nCoV/guidance-hcp.html>
 - Information for Laboratories: <https://www.cdc.gov/coronavirus/2019-nCoV/lab/index.html>
 - Laboratory Biosafety: <https://www.cdc.gov/coronavirus/2019-nCoV/lab/lab-biosafety-guidelines.html>
 - Specimen Collection: <https://www.cdc.gov/coronavirus/2019-nCoV/lab/guidelines-clinical-specimens.html>



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U.S. Food and Drug Administration (FDA)

- General: <https://www.fda.gov/emergency-preparedness-and-response/counterterrorism-and-emerging-threats/coronavirus-disease-2019-covid-19>
- Emergency Use Authorizations: <https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization>

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Checking eligibility and/or benefit information and/or the fact that a service has been preauthorized/pre-notified is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have any questions, call the number on the member's ID card.

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