BlueCross BlueShield of New Mexico

COVID-19: FAQs for Medicare Providers

May 8, 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 New Mexico (BCBSNM) will continue to follow the applicable guidelines from the New Mexico Department of Health and 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 (HMO)℠**
- **Blue Cross Group Medicare Advantage (PPO)℠**
- **Blue Cross Group Medicare Advantage Open Access (PPO)℠**
- **Blue Cross Medicare Advantage HMO**
- **Blue Cross Medicare Advantage Dual Care (HMO SNP)℠**
- **Blue Cross Medicare Advantage (PPO)℠**
- **Blue Cross Medicare Supplement℠**

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 BCBSNM 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 BCBSNM for approval to test for COVID-19. Testing must be medically necessary and consistent with Centers for Disease Control and Prevention (CDC) guidance.

Does BCBSNM 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

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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.

Which labs should I use for testing?

BCBSNM contracted providers are encouraged to use in-network labs that are equipped to provide testing. The New Mexico Department of Health has information about labs and testing sites.

How should I code COVID-19 testing claims?

If you test a member when it's medically necessary and consistent with CDC guidance, submit the claim to us using the appropriate code:

- Healthcare Common Procedure Coding System (HCPCS) code **U0001** (CDC testing laboratories to test patients for SARS-CoV-2)
- HCPCS code **U0002** (Non-CDC lab test)
- Current Procedural Terminology (CPT®) **87635** (American Medical Association (AMA) code for SARS-2-CoV-2 lab test)
- HCPCS **U0003** (nucleic acid, amplified probe technique for SARS-2-CoV-2, making use of high throughput technologies)
- HCPCS **U0004** (any technique, making use of high throughput technologies)

Modifier CS for testing-related services

Providers should use the CS modifier on applicable claim lines to identify services provided as COVID-19 testing-related services.

How should I code claims for COVID-19 antibodies tests?

If you test a member for COVID-19 antibodies when it's medically necessary, medically appropriate and in accordance with generally consistent medical standards, submit the claim to us using the appropriate code. Member cost-share will be waived.

- **86318** (revised to indicate immunoassay for infectious agent antibodies; single-step method)
- **86328** (new for COVID-19; single-step method)
- **86769** (new for COVID-19; multiple-step method)

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 BCBSNM, that contracted reimbursement rate may apply.

COVID-19 Treatment for Medicare Members

Does BCBSNM 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. Medicare Supplement members do not have network restrictions unless otherwise noted on their plans. **This change applies to costs associated**

with COVID-19 treatment from April 1 through May 31, 2020, but may be extended if needed.
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 ID card or Provider Customer Service at 888-349-3706 for individual and 877-299-1008 for group to speak with a Customer Advocate. (Click here for more details on telemedicine.)

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

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

Is BCBSNM extending current prior authorizations for Medicare Advantage members?

Yes. BCBSNM 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 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 should I code a claim for COVID-19 diagnosis?

Submit your claims for COVID-19 diagnoses using the appropriate code:

- **U07.1** (COVID-19 acute respiratory disease)
- **B97.29** (Other coronavirus as the cause of diseases classified elsewhere)
- **B34.2** (Coronavirus infection, unspecified)
- **Z03.818** (possible exposure to COVID-19)
- **Z20.828** (actual exposure to COVID-19)

See the AMA website and Billing and Coding Guidance FAQs on the CMS website for more information.

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. BCBSNM 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

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  - Example: Locum claims for an MD should be billed under one name and rendering NPI# of the currently contracted MD for your tax ID#
- Locum claims for midlevels (APNs, RNs., 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 tax ID#
- All locum claims must contain a **Q6 modifier** at the claim line level

Due to COVID-19, will BCBSNM 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 call the number on the back of the member ID card or Provider Customer Service at 888-349-3706 for individual and 877-299-1008 for group to speak with a Customer Advocate

Telemedicine for Medicare Members

Has BCBSNM 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 6, 2020. We are continuing to evaluate the evolving landscape relating to COVID-19 and will continue to update our practices accordingly.

Which providers may provide telehealth services to Medicare members?

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

- Physicians
- Physician assistants
- APRNs
- 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 our Provider Services to check eligibility and office visit benefits by calling call the number on the back of the member ID card or Provider Customer Service at 888-349-3706 for individual and 877-299-1008 for group to speak with a Customer Advocate . (Telemedicine is not yet a category offered in our automated Interactive Voice Response (IVR) phone system.)

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- 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. BCBSNM 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.

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 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?

BCBSNM 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 6, 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 BCBSNM helping with prescriptions?
Members of these Medicare plans can get 90-day fills through mail order.

- Blue Cross Group Medicare Advantage (HMO)
- 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/HMO SNP
- Blue Cross Medicare Advantage HMO/HMO POS
- Blue Cross Medicare Advantage (PPO)
- Blue Cross Medicare Rx (PDP)SM
- 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 BCBSNM website for updates. If you have additional questions, contact Provider Customer Service at 888-349-3706.

CMS

- 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

CDC

- 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
- Isolation Precautions in Healthcare Settings: https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html#a4
- Specimen Collection: https://www.cdc.gov/coronavirus/2019-

nCoV/lab/guidelines-clinical-specimens.html

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

This material is for informational and educational purposes only. It is not intended to be a definitive source for coding claims. Health care providers are instructed to submit claims using the most appropriate code(s) based upon the medical record documentation and coding guidelines and reference materials. This material is not a substitute for the independent medical judgment of a physician or other health care provider. Physicians and other health care providers are encouraged to use their own medical judgment based upon all available information and the condition of the patient in determining the appropriate course of treatment. References to third party sources or organizations are not a representation, warranty or endorsement of such organizations. Any questions regarding those organizations should be addressed to them directly. The fact that a service or treatment is described in this material is not a guarantee that the service or treatment is a covered benefit and members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider. Prior authorization for health care services is nota guarantee of payment.

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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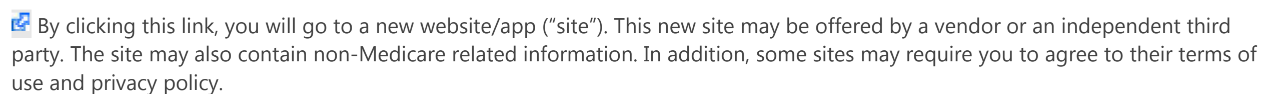

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