At this time, the information provided in this FAQ related to eligibility of additional benefits or services or waiving of copays does not apply to Minnesota Health Care Programs (MCHP).

**Submitting Claims:**

**Q.** What diagnosis codes should be used to identify a COVID-19 related claim?

A. Diagnosis coding should follow the guidelines set forth by the CDC.

[**CDC ICD-10-CM Official Coding Guidelines**](#)

Additionally, Blue Cross is currently reviewing how ICD-10 diagnosis code U07.1 (2019-nCoV acute respiratory disease) will be used when it becomes effective on 4/1/2020.

**Q.** What procedure codes should be used when billing for the lab testing of COVID-19?

A. The following HCPCS codes have been developed and should be used for billing COVID-19 laboratory testing. U0001 and U0002 will be effective beginning with dates of service 2/4/20 and 87635 will be effective beginning with dates of service 3/13/20.

U0001 – coronavirus testing using the Centers for Disease Control and Prevention (CDC) 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel

U0002 – validated non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (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

**Q.** How should a claim be submitted for services other than a COVID-19 lab, so the claim is identified as related to COVID-19?

A. For all services other than COVID-19 labs (U0001, U0002, 87635), Blue Cross requests that providers include the narrative “COVID-19” in the NTE segment on the 837 Electronic Claim Record. Blue Cross will use this narrative to positively ID that the services rendered are related to COVID-19.

Blue Cross recommends the use of the following Loops, Segments and Elements when submitting claims:

- 837I, Loop 2300, NTE02, when NTE01 is DGN.
- 837P, Loop 2300, NTE02, when NTE01 is DGN
- Professional CMS-1500, Field 19
- Institutional UB-04, FL80
Reimbursement of New Lab Codes:

Q. How will the new COVID-19 lab codes be reimbursed on a professional claim (837P)?

A. COVID-19 laboratory tests must be done at approved locations in accordance with CDC guidelines.

Blue Cross will be updating the standard non-RVU fee schedule for COVID-19 testing as follows in accordance with the member’s benefit plan for all lines of business:

- HCPCS U0001: $35.91 – effective 2/4/20 dates of service
- HCPCS U0002: $51.31 – effective 2/4/20 dates of service
- CPT 87635: $51.31 – effective 3/13/20 dates of service

These reimbursement rates are based upon rates that were recently released by the Centers for Medicare and Medicaid Services for COVID-19 testing and established by the local Medicare Administrative Contractor (MAC).

Note, Minnesota Health Care Programs reimbursement for these services are subject to change based upon an established rate by the Department of Human Services (DHS).

Q. Will the new COVID-19 lab codes be added to the Enhanced Ambulatory Patient Grouper (EAPG) for outpatient facility services?

A. The COVID-19 laboratory tests will be updated in the April EAPG software release.

Member Benefits:

Q. Do laboratory tests for COVID-19 assess member cost share?

A. Member cost share (co-pay, coinsurance, and deductible) is waived for COVID-19 lab testing (U0001, U0002 and 87365) for Medicare and fully insured Commercial lines of business. Currently, Minnesota Health Care Programs (MHCP) is excluded from a waiver of member cost share.

Q. Has Blue Cross waived member cost share for any other services?

A. Member cost share has been waived for eligible services provided by Doctor on Demand through April 13, 2020 for any diagnosis to encourage the use of virtual care in accordance with the member’s benefit plan.

Blue Cross is currently assessing waiving member cost share for additional services and will communicate any changes as they occur.

Q. How long will member cost share be waived?

A. Blue Cross will waive member cost share as described above and will communicate any extensions to that timeframe.
Q. Who should I advise Blue Cross members to contact with benefit questions?

A. Members should contact Member Services at Blue Cross at the phone number on the back of the member’s ID card.

Appeals:

Q. How can a provider assist in identifying an appeal related to COVID-19?

A. Please ensure that the cover sheet or first page of the appeal clearly states “COVID-19” or “Coronavirus”.

Care Management and Notification of Impacted Members:

Q. Does Blue Cross provide any care management support for Blue Cross members diagnosed with COVID-19?

A. Yes, there is care management support available. Blue Cross encourages providers to notify the Plan of all members with a diagnosis or suspected diagnosis of COVID-19. By providing this information, our Care Management nurses can assist with a smooth transition to home if admitted, or support them at home if under self-quarantine, ensuring essential needs are met. Providers can refer a member for care management needs related to COVID-19. To notify Blue Cross of impacted Commercial or Medicare Advantage members, please contact 1-855-579-7657, and for MHCP members, please contact 1-800-711-9862.

Members should contact Member Services using the phone number on the back of the Member’s ID card.

Pharmacy:

Q. Can a member receive an early medication refill?

A. For members who have Prime Therapeutics as their Pharmacy Benefit Manager (PBM), Blue Cross will increase access to prescription medications by waiving early medication refill limits on 30-day prescription maintenance medications. Blue Cross encourages members to use the 90-day mail order benefit, if one exists. Members with PBMs other than Prime Therapeutics should contact their PBM for information. Please note that the early refill waiver does not apply to MHCP members at this time.

Virtual Care (Telehealth, E-Visits, Telephone Visits):

Q. Does Blue Cross reimburse E-Visits, Telehealth and Telephone Visits?

A. Blue Cross currently has policies that allow for reimbursement of eligible E-Visits, Telehealth and Telephone Visits in accordance with the member benefits. Given the nature of the COVID-19 pandemic, seeking in-person medical care may lead to further spreading of the virus. Blue Cross is
currently reviewing its policies to ensure clarity of requirements and coverage. Please refer to the links below for the most up-to-date policies:

*Telehealth Services Reimbursement Policy (Revised 3/20/2020)*  
*E-Visits Reimbursement Policy*  
*Telephone Calls Reimbursement Policy (Revised 3/20/2020)*

**Q. How are telehealth services, billed with place of service 02, reimbursed?**

A. Telehealth services are reimbursed at the same rate as they would be for a face-to-face encounter in an office setting (place of service 11).

**Q. Can telehealth be provided over the telephone with no visual connection?**

A. Blue Cross is waiving the policy requirement of a visual component for the duration of the National Health Emergency related to COVID-19, allowing telehealth services to be provided over the telephone.

**Q. Can telehealth and telephone visits be provided to a new patient?**

A. During the timeframe of the National Health Emergency related to the COVID-19 pandemic, Blue Cross is waiving the restriction of providing telehealth and telephone visits to established patients to allow the services to be provided to new patients.

**Q. What are the requirements for the audio-visual applications being used for telehealth?**

A. In accordance with CMS and to increase the availability of telehealth to members, Blue Cross will waive the HIPAA security requirements and allow common audio-visual apps, such as Skype and Facetime, to be used for telehealth visits.

**Q. Do participating providers need any additional contracts to provide virtual care services?**

A. No additional contracting is needed. The eligible coding and billing requirements are listed in each reimbursement policy.

**Q. Do providers need to submit any information regarding practitioners that will begin providing virtual care services?**

A. No additional credentialing or updates are needed for practitioners to begin providing telehealth services. Practitioners must be licensed in the state where the patient is located when receiving services.

**Q. Can a member be located at home when they receive telehealth services?**

A. Yes, a member can be located at home when they receive telehealth services.

**Q. Can the practitioner be located at home and provide telehealth or telephone visits?**

A. Yes, a practitioner can provide telehealth or telephone services while being located at their home.
Reference Labs:

Q. What labs should providers refer labs to?

A. Providers are required to use FDA approved labs and should refer to a participating lab whenever possible.

Prior Authorizations:

Q. Will any prior authorization requirements be waived?

A. Prior authorizations will not be required for medically necessary services and items related to the diagnosis and treatment of COVID-19. Blue Cross may require medical records if unable to determine if the claim is related to COVID-19 or to determine the medical necessity of the services and items. In the event a prior authorization is submitted to eviCore for COVID-19 related diagnosis and treatment, the prior authorizations will be auto-approved.

Q. Are there any changes to the prior authorization requirements and/or process for DME for patients without COVID-19?

A. eviCore will auto-approve DME codes in the following categories for Medicare Advantage members with COVID-19 and non-COVID-19 diagnoses:
   - Oxygen
   - Nebulizers
   - Ventilators
   - Chest wall precursors
   - Cough stimulating devices and all associated accessories

Prior authorization is not typically required for DME in these categories for commercial members.

Q. Are there any changes to the prior authorization requirements and/or process for Post-Acute Care services?

A. Blue Cross and eviCore will approve all home health care services and skilled nursing facility (SNF) admissions for Medicare Advantage and commercial members with COVID-19 and non-COVID-19 diagnoses as follows:
   - Home Health: Initial home health requests will be approved for 60 days. Home health extension requests will be approved for 30 days at a time until the pandemic has passed.
   - Skilled Nursing Facilities: Admissions from acute care facilities to skilled nursing facilities (SNF) will be approved for the first 7 days to help free up hospital beds.

The provider will still need to notify Blue Cross or eviCore of the request so the admission can be approved and tracked for follow up throughout the length of stay.
Q. How will Blue Cross and eviCore accommodate approved prior authorizations for non-urgent and elective services that have been postponed or delayed due to the COVID-19 outbreak?

A. eviCore and Blue Cross will be working to proactively extend prior authorizations for elective services and some non-urgent non-elective services. The member and provider will get a new letter with the extended approval time period. This information will also be reflected within the Auth/Referral Dashboard in the Availity portal. Non-elective services where the member’s condition may change over time and coverage criteria may no longer be met if the service is delayed will not be extended and may need a new authorization when the service is rescheduled.

Business Resiliency:

Q. Does Blue Cross have any concerns with timely processing of claims that will negatively impact provider payment?

A. Blue Cross has plans in place to ensure timely processing of claims and does not anticipate any delay. In the event providers experience a financial hardship that threatens the ability to continue operations, Blue Cross has policies in place to support providers in order to preserve access to care for Subscribers in extreme circumstances.

Q. If a provider is unable to submit claims timely due to staffing impacts as a result of COVID-19, will Blue Cross allow additional time?

A. Blue Cross will continue to monitor how the COVID-19 pandemic impacts core business operations for providers. In the event, Blue Cross makes any changes to accommodate delays in claims submissions, Blue Cross will notify providers.

Practitioner Credentialing and Enrollment:

Q. What is Blue Cross doing to facilitate quicker practitioner credentialing and enrollment?

A. Blue Cross has moved all new credentialing applications and practitioner add requests to our top priority.

Additionally, Blue Cross will implement a provisional credentialing process to more quickly credential providers and will follow the NCQA change from a 60 day to a 180-day time frame for the provisional status.

Requirements for the provisional credentialing include the following:

- Valid license to practice
- 5-year history of malpractice claims or National Practitioner Data Bank Query
- A current and signed application with attestation

Q. Is Blue Cross extending the timeframe for recredentialing?

A. Blue Cross will follow the NCQA recommendation to extend the recredentialing cycle from 36 months to 38 months to allow providers additional time to complete recredentialing.
Q. What will happen if a practitioner needs to work at a different location from one which they are currently enrolled? How can claim denials be limited for this scenario?

A. If providers need to practice at different locations than currently set up, there are three potential options to limit claim denials for this situation (these options only apply to practitioners that do not require credentialing or are current with credentialing):

- Submit the site of care as their primary clinic location even if care is not rendered at that clinic
- Notify us of the additional clinic location and these requests will be worked as a priority
- Notify us post care and we will back date the effective date to the first date care was provided