



**COVID-19 Preparedness
Answers to Frequently Asked Questions (FAQs) from Providers
(Updated September 2020)**

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1. OVERVIEW

Blue Cross and Blue Shield of Illinois (BCBSIL) launched an expanded telehealth program on March 10, 2020, in quick response to the COVID-19 crisis. In alignment with Governor J.B. Pritzker's Executive Order regarding health insurance benefits and new Illinois requirements, our response to COVID-19 continues to evolve as we work to provide even greater access to services for our members during this time. We are committed to working with providers to inform and provide greater clarity around our expanded telehealth program and related changes during this crisis transition time through alerts, provider communications, and our member benefit and eligibility call centers and systems.

The purpose of this FAQ document is to help address specific questions we are hearing from providers. Most of the information applies to providers who provide care and services to BCBSIL commercial and government programs members. **However, please note that section 10 includes additional information that is specific to government programs.**

This document is evolving and will be updated as more information becomes available. Please continue to refer to our [COVID-19 Preparedness page](#) and [News and Updates](#) for additional announcements.

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2. COVERAGE / MEMBER ELIGIBILITY

Will BCBSIL cover testing for COVID-19?

Members won't pay copays, deductibles or coinsurance with in-network or out-of-network providers for lab tests to diagnose COVID-19. A member's doctor does NOT have to ask BCBSIL for the OK to test for COVID-19. **For testing-related visits**, members won't pay copays, deductibles or coinsurance with in-network providers for visits related to ordering or administering the COVID-19 diagnostic tests whether at a provider's office, urgent care clinic, emergency room or by telehealth. (See section 7, [TESTING](#), for more information.)

What are appropriate "associated services" under the federal law?

The federal legislation requires coverage of items and services (associated services) that are provided to an individual during a provider office visit (whether face-to-face or telehealth), urgent care visit, or emergency room visit that:

- Results in the order for, or administration of a COVID-19 test; **and**
- Relates to either the furnishing or administration of the test or evaluation of the individual for purposes of determining whether that individual needs the test.

Will BCBSIL cover treatment for COVID-19?

We have taken steps to lower costs and provide easier access to care for our PPO, Blue Choice PPOSM and HMO members, as well as Blue Cross Community Health PlansSM (BCCHPSM), Blue Cross Community MMAI (Medicare-Medicaid Plan)SM.and Blue Cross Medicare AdvantageSM members.

Our plans cover medically necessary health benefits, including physician services, hospitalization and emergency services consistent with the terms of the member's benefit plan. Members should always call the number on their BCBSIL member ID card for answers to their specific benefit questions. BCBSIL is waiving member cost-sharing, including deductibles, copayments and coinsurance related to **treatment** for COVID-19. The waiver applies to costs associated with COVID-19 treatment by providers, including facilities, so long as the treatment is covered and provided consistent with the terms of the member's benefit plan. We will work with self-funded employer groups that decide to waive cost-share for treatment.

BCBSIL encourages members to continue to seek health care treatment from in-network participating providers.

Members receiving out-of-network COVID-19 treatment from providers, including facilities, will also have cost-share waived, so long as the COVID-19 treatment is covered and provided consistent with the terms of the member's benefit plan. However, if a member receives COVID-19 treatment from an out-of-network provider, any waiver of cost-share does not protect a member from provider balance or surprise billing. Members may be subject to balance or surprise billing depending on their benefit plan terms and state or federal laws since a provider may not accept the amount covered under the benefit plan as payment in full.

How long will cost-sharing for treatment of COVID-19 be waived?

The waiver applies to treatment received April 1, 2020, **through Oct. 23, 2020**. We will reassess this waiver as events warrant.

If a member is quarantined at home, will BCBSIL cover doctor visits to the home?

Physician home visits, if available and offered, will be covered as indicated by the member or group plan participant's benefit coverage terms.

Do employer group plan participants have a telehealth benefit?

An employer group's telehealth benefits may differ depending upon the individual's benefit plan, including if an individual is covered through the individual's employer's self-funded plan.

Note: Many of our members are covered under a health plan that is self-insured by their employer. Some of these members may not have telehealth benefits, or may be responsible for co-pays, deductibles, and coinsurance for telehealth based on their employer's election. [See the [TELEHEALTH \(GENERAL\)](#) and [TELEHEALTH \(BEHAVIORAL HEALTH\)](#) sections below for more information.]

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Do Illinois fully-insured PPO, Blue Choice and HMO members have a telehealth benefit?

As noted in previous communications, we expanded our telehealth program for all state-regulated, fully-insured members in response to the COVID-19 pandemic. BCBSIL will continue to provide expanded telehealth benefits for all fully-insured members for health care services provided by in-network and out-of-network providers for all medically necessary covered services and treatments consistent with the terms of the member's benefit plan **through Dec. 31, 2020**. All medically necessary health care services delivered via telehealth for fully-insured PPO and Blue Choice PPO members will be covered in accordance with the member's benefits for covered services. Telehealth benefits for medically necessary services are also available to HMO members (in accordance with the details of their health plan) from providers in their in-network medical group who offer telehealth.

Do members in government programs like Medicare Advantage, MMAI or Medicaid have a telehealth benefit?

BCBSIL will continue to follow the applicable guidelines of the Illinois Department of Human Services and Centers for Medicare & Medicaid Services (CMS) as appropriate for BCCHP, MMAI and Blue Cross Medicare Advantage (PPO)SM members. BCBSIL Medicare Advantage and MMAI plans have temporarily expanded telehealth benefits. BCBSIL will waive cost-share when Medicare Advantage beneficiaries access telehealth services from in-network providers. **(Also see section 10, [ADDITIONAL INFORMATION FOR GOVERNMENT PROGRAMS.](#))**

How can we confirm coverage/check benefits for telehealth/telehealth?

While eligibility and benefits information for most members/services can be obtained by submitting an electronic 270 transaction, telehealth-specific services are not defined in the electronic eligibility and benefits response. Also, telehealth is not a category offered currently in our automated Interactive Voice Response (IVR) phone system. For telehealth benefits, please call our Provider Telecommunication Center (PTC) at 800-972-8088 to request Office Visit benefits and request to speak with an agent for telehealth-specific information.

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3. CREDENTIALING / TEMPORARY HEALTH CARE WORKERS

Are out-of-state health care providers not licensed in Illinois able to continue to provide services to Illinois patients?

The Department of Financial and Professional Regulation interprets the Governor's Order to permit an out-of-state health care provider not licensed in Illinois to continue to provide health care services to an Illinois patient via telehealth where there is a previously established provider/patient relationship.

How is BCBSIL's credentialing process being simplified for COVID-19?

We are temporarily updating our credentialing policy and processes in response to the COVID-19 emergency. Subject to state actions on licensing and practice requirements, we will credential providers for the duration of the state-declared emergency or as specified by state requirements, as follows:

- We will accept practitioners who hold a full unrestricted license to practice, granted by any state, subject to the state's emergency provider licensure laws. We will accept temporary licenses.
- We will waive accreditation requirements, CMS certification and site visits for institutional providers.
- We will accept expired documents if they have been inactive or expired for less than six-months and the provider is unable to obtain a current document from the issuer due to the COVID-19 emergency. Licenses, accreditations or certifications that have been revoked for cause will not be accepted.

How long are temporary health care workers allowed to provide services?

This complies with emergency state and federal regulations and is effective **April 3, 2020**. The temporary modifications are only in place during the COVID-19 emergency and subject to change based upon state and federal action. Otherwise, standard credentialing and processes will apply.* Credentialing criteria and verification sources may change.

**This does not apply to providers participating in Blue Cross Community Health Plans (BCCHP) (Medicaid Plans) and Blue Cross Community MMAI Plans (Medicare-Medicaid Plan) networks.*

Which BCBSIL members can temporary health care workers treat?

Approved temporary health care providers may treat all BCBSIL members.

Will claims be expedited?

Temporary health care worker claims for services provided to BCBSIL members will be adjudicated according to normal processes and timeframes. Claims submitted previously should not be resubmitted.

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4. PREAUTHORIZATION / UTILIZATION MANAGEMENT

Is preauthorization required for telehealth visits?

Telehealth office visits related to COVID-19 will not be subject to benefit preauthorization requirements. However, if a particular health care service typically provided in an in-person face-to-face setting required prior authorization prior to March 19, 2020, and that same service is now planned to be provided via telehealth, prior authorization will still be required for that service. If prior authorization was already obtained for a face-to-face service, an additional prior authorization to provide the service via telehealth is not required.

What about prior authorization for interfacility transfers?

BCBSIL implemented an accommodation on April 1, 2020, to make it easier to transfer our members from acute-care facilities to in-network, medically necessary alternative post-acute facilities **through May 15, 2020**.

During this accommodation period, post-acute care facilities did not need to wait for prior authorization to transfer our members from an inpatient hospital to an in-network medically appropriate, post-acute site of care such as long-term acute care hospitals, skilled nursing facilities, rehabilitation facilities and in-patient hospice. The receiving facility was required to call and inform us of the transfer by the next business day.

This accommodation ended on May 15, 2020. A [News and Updates notice](#) was posted to remind providers to revert to processes in place before April 1, 2020.

Does this apply to the actual air/ground transfer, too?

No. Prior authorization is still required for air/ground transportation services.

Does this apply to out-of-state members?

There are no changes to the out-of-area (BlueCard®) program. The utilization management requirements of the member's home plan still apply.

Is clinical documentation needed for prior authorization request through eviCore for chest CT scans with a COVID-19 diagnosis?

With the rapidly evolving COVID-19 public health crisis, BCBSIL is temporarily simplifying access to chest computed tomography (CT). As of March 2, 2020, providers that request prior authorization through eviCore healthcare (eviCore) for chest CT scans with a COVID-19 diagnosis will receive an approval without the need for clinical documentation. We are also temporarily waiving the need for members to notify us when they are scheduled to have a chest CT scan. (See the [News and Updates notice](#) for additional information.)

If I already received prior authorization on an elective surgery, procedure or therapy that was postponed/delayed, do I need to submit a new prior authorization request prior to rescheduling services?

We're temporarily extending approvals on services with existing prior authorizations until **Dec. 31, 2020**. This applies to services that were originally approved or scheduled between Jan. 1, 2020, and June 30, 2020. The extension is for certain non-emergent, elective surgeries, procedures, therapies and home visits. A member may reschedule an approved procedure to a later date in 2020 without requiring a new prior authorization. This applies only to current members for a benefit that is covered under their plan at the time services are rendered. (See the [News and Updates notice](#) for more information.)

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5. TELEHEALTH (GENERAL)

How long will the expanded telehealth program be in place?

Background: On March 28, 2020, BCBSIL expanded telehealth benefits for all state-regulated, fully-insured members in response to the Covid-19 pandemic. BCBSIL expanded these benefits for the duration of Illinois Governor J.B. Pritzker's Gubernatorial Disaster Proclamation.

Update as of May 15, 2020: BCBSIL will continue to provide expanded telehealth benefits for all fully-insured members for health care services provided by in-network and out-of-network providers for all medically necessary covered services and treatments consistent with the terms of the member's benefit plan **through Dec. 31, 2020**. Any coverage or fee schedule changes for telehealth benefits will be communicated 90 days in advance. Check the [News and Updates](#) and [Blue Review](#) for future updates to BCBSIL's telehealth program.

What types of providers can render services via telehealth?

The Governor's Order defines available telehealth services as those services that include the provision of health care, psychiatry, mental health treatment, substance use disorder treatment, and related services. Telehealth services may be rendered by providers to deliver any medically necessary covered services and treatments to fully-insured members consistent with the terms of each member's benefits. This means that providers may include, but are not necessarily limited to, physicians, physician assistants, optometrists, advanced practice registered nurses, and clinical psychologists licensed in Illinois, prescribing psychologists licensed in Illinois, dentists, occupational therapists, pharmacists, physical therapists, clinical social workers, speech-language pathologists, audiologists, hearing instrument dispensers, and mental health professionals and clinicians authorized by Illinois law to provide mental health services. In addition, while not required by law, or the Governor's Executive Order, BCBSIL also recognizes licensed dietitians and nutritionists as providers of telehealth services and will cover such services for fully-insured members so long as benefits are available in accordance with the terms of the member's health benefit plan. If a dietician or nutritionist is in-network with BCBSIL, and coverage for such services is available under the terms of a fully-insured member's benefits, cost-sharing will be waived **through Dec. 31, 2020** (previously Sept. 30, 2020).

For state-regulated fully-insured BCBSIL member plans, is telehealth covered for physical therapy, occupational therapy, and speech therapy services?

Previously, we announced that telehealth claims for insured members submitted by physical therapy, occupational therapy, and speech therapy providers, in accordance with appropriate coding guidelines, including appropriate modifiers, for in-network medically necessary health care services beginning March 19, 2020, will be covered without cost-sharing and will be reimbursed at parity with in-person office visits¹ for the duration of the Gubernatorial Disaster Proclamation. BCBSIL will continue to provide expanded telehealth benefits for all fully-insured members for health care services provided by in-network and out-of-network providers for all medically necessary covered services and treatments consistent with the terms of the member's benefit plan **through Dec. 31, 2020**. Any coverage or fee schedule changes for telehealth benefits will be communicated 90 days in advance. Check the [News and Updates](#) and [Blue Review](#) for future updates to BCBSIL's telehealth program.

For state-regulated fully-insured BCBSIL member plans, is telehealth covered for behavioral health services?

Previously, we announced that telehealth claims for insured members submitted by behavioral health providers, in accordance with appropriate coding guidelines, including appropriate modifiers, for in-network medically necessary health care services beginning March 19, 2020, will be covered without cost-sharing and will be reimbursed at parity with in-person office visits² for the duration of the Gubernatorial Disaster Proclamation. BCBSIL will continue to provide expanded telehealth benefits for all fully-insured members for health care services provided by in-network and out-of-network providers for all medically necessary covered services and treatments consistent with the terms of the member's benefit plan **through Dec. 31, 2020**. Any coverage or fee schedule changes for telehealth benefits will be communicated 90 days in advance. Check the [News and Updates](#) and [Blue Review](#) for future updates.

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¹ For telehealth providers who do not offer an "in-office" visit option, such as MDLIVE®, reimbursement will continue to be at the same level as it was prior to the Governor's Executive Order.

² For telehealth providers who do not offer an "in-office" visit option, such as MDLIVE, reimbursement will continue to be at the same level as it was prior to the Governor's Executive Order.

For state-regulated fully-insured member plans, or employer group sponsored plans, is BCBSIL waiving copays and deductibles for telehealth visits?

Telehealth claims for insured members submitted in accordance with appropriate coding guidelines, including appropriate modifiers, for in-network medically necessary health care services beginning March 18, 2020, will be covered without cost-sharing and will be reimbursed at parity with in-person office visits³ through Dec. 31, 2020 (previously Sept. 30, 2020).

In addition, a member's telehealth benefits may differ depending upon the individual's benefit plan, including if an individual is covered through the individual's employer's self-funded plan. Application of cost-sharing may also differ by the individual's plan.

Note: Some self-insured plan members may be responsible for copays, coinsurance or deductibles, based on their employer's election to participate in this benefit.

Do members have to use BCBSIL's telehealth vendor?

No. Eligible members may obtain services through MDLIVE®, or they may obtain services via telehealth with non-MDLIVE in-network or out-of-network providers and coverage will be provided by BCBSIL in accordance with the terms of the member's benefit plan. Usage of out-of-network providers may increase a member's out-of-pocket responsibilities. In addition, as we announced previously, telehealth claims for insured members submitted in accordance with appropriate coding guidelines, including appropriate modifiers, for in-network medically necessary health care services beginning March 19, 2020, will be covered without cost-sharing and will be reimbursed at parity with in-person office visits⁴ for the duration of the Gubernatorial Disaster Proclamation. BCBSIL will continue to provide expanded telehealth benefits for all fully-insured members for health care services provided by in-network and out-of-network providers for all medically necessary covered services and treatments consistent with the terms of the member's benefit plan through Dec. 31, 2020. Any coverage or fee schedule changes for telehealth benefits will be communicated 90 days in advance. Check the [News and Updates](#) and [Blue Review](#) for future updates to BCBSIL's telehealth program.

Note: HMO members should contact their Primary Care Physician and/or IPA to request telehealth services.

How can telehealth be conducted?

Available telehealth visits with BCBSIL providers currently include 2-way, live interactive telephone communication and digital video consultations, and other methods allowed by state and federal laws, which can allow members to connect with physicians while reducing the risk of exposure to contagious viruses or further illness. 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](#).⁵

Can licensed clinicians conduct telehealth visits using a HIPAA-compliant video conferencing platform from their electronic medical record (EMR) systems from their homes or offsite from their clinics?

Yes. Please see the [U.S. Department of Health and Human Services notification about telehealth](#).

How do I code telehealth visits? Do I need to do anything differently to provide and be compensated for telehealth services?

Submit claims for telehealth services using the appropriate Current Procedural Terminology (CPT®)/Healthcare Common Procedure Coding System (HCPCS) codes. Procedures not defined as telehealth-specific must be appended with the appropriate modifier(s). You do not need to do anything differently – just submit your claims with the approved codes and modifier(s).

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³ For telehealth providers who do not offer an "in-office" visit option, such as MDLIVE, reimbursement will continue to be at the same level as it was prior to the Governor's Executive Order.

⁴ For telehealth providers who do not offer an "in-office" visit option, such as MDLIVE, reimbursement will continue to be at the same level as it was prior to the Governor's Executive Order.

⁵ HIPAA-compliant remote technologies may not be required for telehealth services provided to fully-insured members consistent with the terms of the Governor's Executive Order.

What are the appropriate telehealth modifiers that should be used?

In addition to all other required information, claims for telehealth services must include the 95 or GT modifiers, as appropriate and applicable. BCBSIL will accept both of these modifiers on claims for telehealth services submitted to BCBSIL.

What are the appropriate place of service codes?

Providers may use Place of Service Code 02 (TeleHealth) or another appropriate place of service code along with the 95 or GT modifiers.

How should I submit telehealth claims for Nutrition Counseling and Dietician related services?

Nutrition Counseling and Dietitian codes 97802, 97803, 97804, 98960, 98961, 98962, G0108, G0109, G0270, G0271, G0447, G0473, S9470 will be accepted for in-network and out-of-network providers that have chosen to provide medically necessary services via telehealth where a member has coverage for such services. Cost-sharing will be waived for fully-insured members who are treated by in-network providers.

What are the COVID-19 diagnosis codes?

- U07.1 (COVID-19 acute respiratory disease)
- B97.29
- B34.2
- Z03.818 (possible exposure to COVID-19)
- Z20.828 (actual exposure to COVID-19)

Are telehealth visits limited to COVID-19 diagnosis codes (or with a COVID-19 modifier)?

No, telehealth visits are not limited to claims with a COVID-19 diagnosis codes. If applicable, claims should be submitted with the appropriate modifier and approved telehealth CPT/HCPCS codes. For information on how to select the appropriate corresponding ICD-10 codes, you may review the [Centers for Disease Control and Prevention \(CDC\) guidance](#).

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6. TELEHEALTH (BEHAVIORAL HEALTH)

Does BCBSIL's telehealth coverage include behavioral health services?

Previously, we announced that telehealth claims for insured members submitted by behavioral health providers, in accordance with appropriate coding guidelines, including appropriate modifiers, for in-network medically necessary health care services beginning March 19, 2020, will be covered without cost-sharing and will be reimbursed at parity with in-person office visits⁶ for the duration of the Gubernatorial Disaster Proclamation. Out-of-network behavioral health services for fully-insured members will be covered consistent with the member's benefit plan, including cost-sharing. Members may experience greater out-of-pocket costs if they choose to see an out-of-network provider. BCBSIL will continue to provide expanded telehealth benefits for all fully-insured members for services provided by in-network and out-of-network providers for all medically necessary covered services and treatments consistent with the terms of the member's benefit plan **through Dec. 31, 2020**.

Keep in mind that an employer group's telehealth benefits may differ depending upon the individual's benefit plan, including if an individual is covered through the individual's employer's self-funded plan.

How should I submit telehealth claims for Applied Behavioral Analysis (ABA) services?

ABA codes 97151, 97153, 97155, 97156, and 97157 will be accepted for in-network and out-of-network providers that have chosen to provide medically necessary services via telehealth where a member has coverage for such ABA services and will be covered consistent with the terms of the member's benefit plan. Cost-sharing will be waived for fully-insured members who are treated by in-network providers. Prior authorization will be required for applicable codes (e.g., 97513, 97155, 97156 and 97157). It is important to note that employer benefits for telehealth may differ by plan.

Will BCBSIL allow telehealth for partial hospitalization programs (PHP) and intensive outpatient programs (IOP)?

Previously, we announced that telehealth claims for insured members submitted by PHP and IOP providers, in accordance with appropriate coding guidelines, including appropriate modifiers, for in-network medically necessary health care services beginning March 19, 2020, will be covered without cost-sharing and will be reimbursed at parity with in-person office visits⁷ for the duration of the Gubernatorial Disaster Proclamation. Out-of-network PHP/IOP provider claims for fully-insured members will be covered consistent with the member's benefit plan, including cost-sharing. Members may experience greater out-of-pocket costs if they choose to see an out-of-network provider. BCBSIL will continue to provide expanded telehealth benefits for all fully-insured members for health care services provided by in-network and out-of-network providers for all medically necessary covered services and treatments consistent with the terms of the member's benefit plan **through Dec. 31, 2020**. Any provider reimbursement or fee schedule changes for telehealth benefits will be communicated 90 days in advance. Check the [News and Updates](#) and [Blue Review](#) for future updates to BCBSIL's telehealth program.

Note: Outpatient facility claims (UB-04/8371) should be billed using the appropriate procedure code with the GT or 95 modifiers and the appropriate behavioral health revenue code (900-919). Claims must also use the GT and 95 modifiers as appropriate and applicable.

Keep in mind that an employer group's telehealth benefits may differ depending upon the individual's benefit plan, including if an individual is covered through the individual's employer's self-funded plan.

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⁶ For telehealth providers who do not offer an "in-office" visit option, such as MDLive, reimbursement will continue to be at the same level as it was prior to the Governor's Executive Order.

⁷ For telehealth providers who do not offer an "in-office" visit option, such as MDLive, reimbursement will continue to be at the same level as it was prior to the Governor's Executive Order.

7. TESTING

Does BCBSIL cover the cost of testing and testing-related visits for COVID-19?

We have taken steps to lower costs and provide easier access to care for our fully-insured commercial members, and employer group plan participants related to COVID-19:

- **Testing** – Members won't pay copays, deductibles or coinsurance with in-network or out-of-network providers for lab tests to diagnose COVID-19.
- **Testing-Related Visits** – A member won't pay copays, deductibles or coinsurance with in-network providers for visits related to ordering or administering the COVID-19 diagnostic tests whether at a provider's office, urgent care clinic, emergency room or by telehealth.

No prior authorization is needed for testing or testing-related visits. No referrals or lab orders are needed for a member to be tested for COVID-19. A member can be tested more than once.

How should we direct members for diagnostic testing?

See the [CDC website](#) for the latest information on diagnostic test availability.

If someone is not presenting COVID-19 symptoms but wants to be proactively tested, will testing be covered?

To be covered, testing to diagnose COVID-19 must be medically necessary and consistent with the [CDC guidelines](#).

Which labs should I use for testing?

BCBSIL contracted providers are encouraged to use in-network labs who are equipped to provide testing. The Illinois Department of Public Health has information about [labs and testing sites](#).

What are the requirements for specimen collection and testing?

See the [CDC guidelines](#) for the latest information on testing. In general, testing must be:

- For individualized diagnosis or treatment of COVID-19
- Medically appropriate
- In accordance with generally accepted standards of care, including the CDC guidance as appropriate

How should I code COVID-19 claims for specimen collection and testing?

If you are collecting a COVID sample from a member, have a lab capable of testing, or are a lab testing a member when it's **medically necessary and consistent with [CDC guidance](#)**, submit the claim using the **appropriate collection or lab code**. Member cost-share for the specimen collection/test will be waived during the public health emergency, regardless of the diagnosis.

For COVID-19 **specimen collection**, submit claims to BCBSIL using the appropriate code:

COVID-19 Collection Codes	Descriptions
HCPCS C9803	Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) any specimen source
HCPCS G2023	Specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), any specimen source
HCPCS 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

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For COVID-19 **testing**, submit the claim to BCBSIL using the appropriate code:

COVID-19 Lab Codes	Descriptions
CPT 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
CPT 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
CPT 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])
CPT 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
HCPCS U0001	CDC 2019 Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel
HCPCS U0002	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC
HCPCS 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
HCPCS 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

What about COVID-19 testing before non-COVID-19 treatment or procedures?

When screening for COVID-19 before elective procedures or treatment not related to COVID-19 active disease or suspicion, **bill the test on a separate claim** from the rest of the services being rendered. By doing this, we will ensure our members receive the cost-share waiver for COVID testing and the claim will be processed promptly. The **appropriate benefits will apply to the remainder of each member's non-COVID related care**. The diagnosis code **Z11.59** may be used on these claims but is not required.

What are the antibody testing requirements?

Antibody tests must be U.S. Food and Drug Administration (FDA) authorized, including Emergency Use Authorized (EUA). Antibody testing should be medically appropriate for the member and ordered by a health care provider. We encourage members to consult with their health care provider to determine the best, medically appropriate test for their condition. Refer to the [current FDA position on antibody testing](#). Medical or invoice records may be requested to support if an antibody test is FDA authorized or if EUA approval has been requested.

What are the COVID-19 antibodies testing codes?

If you test a member for COVID-19 antibodies when it's medically necessary, medically appropriate and in accordance with generally consistent medical standards and CDC guidelines, submit the claim to BCBSIL using the appropriate code (see below). Member cost-share (copay, deductibles and coinsurance) will be waived for antibody tests that are FDA authorized, including tests with EUA, regardless of the diagnosis. This waiver will last through the end of the Public Health Emergency. Medical or invoice records may be requested to support if an antibody test is FDA authorized or if EUA approval has been requested.

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COVID-19 Antibody Testing Codes	Descriptions
CPT 0224U	Antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), includes titer(s), when performed
CPT 86318	Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single step method
CPT 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)
CPT 86769	Severe Acute Respiratory Syndrome Coronavirus 2 [SARS-CoV-2] [Coronavirus disease (COVID-19)] testing via multiple-step method

How do I indicate services billed are related to COVID-19 testing or antibody testing for BCBSIL members?

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	Descriptions
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)

What modifier is used to identify the service as subject to the cost-sharing waiver?

For services furnished on March 18, 2020, through the end of the Public Health Emergency, 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**.

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8. PHARMACY

How is BCBSIL going to help with prescriptions?

We have temporarily lifted restrictions on getting early prescription fills.

- Members can contact their pharmacy directly to ask for an early fill and any delivery options.
- Pharmacists have approval to provide an early fill on most medications.
- Members can also use their 90-day supply benefits for [covered non-specialty medications](#) at select retail pharmacies or [home delivery \(mail order\)](#). Log in to [Prime Therapeutics](#) or call the number on the member's BCBSIL member ID card.

Please note: This early fill information applies if a member has BCBSIL pharmacy benefits administered by Prime Therapeutics. Also, all safety measures, prior authorization reviews, as well as prescribing and dispensing laws, still apply.

Members can contact the number on their BCBSIL member ID card to inquire about their pharmacy benefits or if they need help with other benefit questions.

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9. CLAIM PROCESSING & REIMBURSEMENT

How do I bill for COVID-19 testing and treatment?

Submit claims for services using the appropriate CPT/HCPCS codes and any applicable modifiers. See the [TELEHEALTH \(GENERAL\)](#), [TELEHEALTH \(BEHAVIORAL HEALTH\)](#) and [TESTING](#) sections for more information.

What dates of service are included in the telehealth expansion?

BCBSIL's telehealth expansion for fully-insured member claims began on March 11, 2020, and then expanded again on March 18, 2020. BCBSIL will continue to provide expanded telehealth benefits, if applicable for all fully-insured members for health care services provided by in-network and out-of-network providers for all medically necessary covered services and treatments consistent with the terms of the member's benefit plan **through Dec. 31, 2020**.

Changes to cost-share for in-network telehealth benefits for fully-insured members were effective on March 18, 2020, and will continue **through Dec. 31, 2020**.

Do you anticipate a delay in claims processing and payment?

At the present moment, we are not experiencing claims processing or payment delays. In the event that such delays occur, we will work to communicate with the provider and member communities. Our Business Resiliency Plan, whether it's for a natural disaster, power outage, or a global outbreak of disease like COVID-19, is designed to help ensure operational resiliency and minimize the impact of potential disruptions to our membership and business partners: In short, the goal of the program is to ensure BCBSIL remains open for business to best serve our members.

What is the reimbursement rate for telehealth visits with in-network and out-of-network providers?

BCBSIL will continue to provide expanded telehealth benefits for all fully-insured members for health care services provided by in-network and out-of-network providers for all medically necessary covered services and treatments consistent with the terms of the member's benefit plan **through Dec. 31, 2020**. Any provider reimbursement or fee schedule changes for telehealth benefits will be communicated 90 days in advance. Check the [News and Updates](#) and [Blue Review](#) for future updates to BCBSIL's telehealth program.

Out-of-network provider claims for fully-insured members will be covered consistent with the member's benefit plan, including cost-sharing. Members may experience greater out-of-pocket costs if they choose to see an out-of-network provider.

How should a claim be billed when services are 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. BCBSIL recognizes the efforts of temporary providers willing to help during the COVID-19 outbreak.

To help 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 Identifier (NPI).
- Locum claims for medical doctors should be billed under one supervising medical doctor.
 - Example: Locum claims for an M.D. should be billed under one name and rendering NPI of currently contracted M.D. for the corresponding 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 a currently contracted midlevel for the corresponding tax ID.
- All locum claims must contain a **Q6 modifier** at the claim line level.

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10. ADDITIONAL INFORMATION FOR GOVERNMENT PROGRAMS

General Information – BCCHP

Where should we direct members that have health questions?

Members who believe that they are experiencing an emergency or require emergency care should call 911. Members in non-emergent circumstances should call their PCP to seek medical care and determine if they need to be seen by a physician.

The 24/7 Nurse Hotline is also available to answer member questions 24 hours a day, 7 days a week. The call is free. BCCHP members should call 888-343-2697.

Is there a general phone number for members to call for help (not related to medical care)?

The BCCHP customer service phone lines will remain open. Members can call BCCHP customer service at 877-860-2837 for assistance related to medication refills, finding providers and more.

For other assistance, help with community resources and in-home services members can also call our BCCHP care coordination hotline at 855-334-4780.

COVID-19 Testing – BCCHP

Is COVID-19 testing covered for BCCHP members?

Yes, all diagnostic tests for COVID-19 and COVID-19 related medical care is covered with no prior authorizations required. There is no cost-share or copay.

Services provided to BCCHP members are reimbursed for U0001 and U0002 at the CMS published rates.

Where do our members go for testing?

If a member believes they need to be tested for COVID-19, when possible, they should talk to their PCP first. Members who believe that they are experiencing an emergency or require emergency care should call 911.

Pharmacy – BCCHP

Can members get their prescriptions delivered?

Yes. BCCHP members can get most prescriptions delivered and can set up mail-order service directly over the phone or online at alliancerxwp.com/home-delivery.

Can members get more than a 30-day supply of medications?

Yes, for maintenance medications members can get a 90-day supply at retail pharmacies if their doctor has prescribed the medicine for 90-days. This excludes controlled substances and non-maintenance medications. Members can also get 90-day fills through mail order. Members can register at alliancerxwp.com/home-delivery.

Can members get an early refill?

Yes, in some cases. Members should speak to their pharmacy for early refill requests. If appropriate, the pharmacy can override the early refill reject. This override also allows out-of-network pharmacies to fill prescriptions. This does not override formulary safety edits.

What if a member leaves the state of Illinois? Can they still get their prescriptions refilled early?

Yes, members can get early refills out of state, if needed.

What if the member's prescription is out of refills?

Members are encouraged to speak to their doctors. A pharmacist may also exercise professional judgment to dispense an emergency supply of medication for a chronic disease or condition if the pharmacist is unable to obtain refill authorization. The member must go to the pharmacy that filled the previous prescription. Controlled substances are excluded. This is usually limited to a 3-day supply.

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What if a pharmacy runs out of medication?

Prime is monitoring medication supplies and is prepared to consider coverage of non-formulary medications in case of any shortages or short-supply of drugs and compounds.

Are Over the Counter (OTC) items covered for BCCHP members?

Yes, OTC items are part of the value-added benefits for BCCHP members. The OTC benefit covers items such as First Aid Supplies, Pain Relievers, Vitamins, Personal Care Items, Allergy Medications and more.

For more information on OTC benefits, please consult the [BCCHP member website](#).

To place an order, BCCHP members can call Customer Service at 877-860-2837.

Access to Care – BCCHP

If a member is diagnosed with COVID-19, will their care be covered?

Yes, inpatient and outpatient medically-necessary care for COVID-19 is covered pursuant to their Medicaid benefits. If members who have been ordered to self-quarantine at home need assistance with meals or activities of daily living and do not have social supports, they should call 855-334-4780.

Is BCBSIL covering anything additional to support BCCHP members?

- All COVID-19 testing and COVID-19 medically necessary related services are covered.
- Out-of-network medically necessary services are covered.
- Home-delivered food for individuals who are required to self-quarantine or do not have access to food/nutrition are covered. Members should speak with a care coordinator to get home-delivered meals.
- Transportation via ride share companies for individuals who need access to urgent medical appointments are covered when no Medicaid transportation is available. All transportation must be set up by LogistiCare Solutions, LLC (LogistiCare).
- Telehealth and E-Visits or Virtual Visits are covered with Medicaid participating providers.
- BCCHP Care Coordination is partnering with community resources to assist members with additional needs such as housing, financial, nutrition.

What can we do to help a member that is diagnosed with COVID-19?

You can help our members know that any medically necessary services related to care for COVID-19 will be covered without member cost-share. In addition, you can let our members know that BCBSIL can assist them in getting the supplies and services they need so they can stay in their homes and get better. This includes delivering prescriptions to their home, ordering home-delivered meals for them, and more.

Community Resources and Helpful Information – BCCHP

Are there any community resources we can direct BCCHP members to for help?

Here are some resources you may wish to suggest to your patients:

- **Chicago Public Schools (CPS)** is offering free food packages that contain three days' worth of food every weekday from 9 a.m. to 1 p.m. CPS is also offering food delivery for families. If a family needs help, they can call CPS's coronavirus command center at 773-553-5437 from 8 a.m. to 5 p.m. Monday through Friday, or email familyservices@cps.edu.
- **Greater Chicago Food Depository** sites are still open and offering pre-packaged boxes of groceries for pick-up.
- **Feeding America** is the nation's largest hunger relief organization. They support thousands of local food pantries, soup kitchens and other feeding centers offering free food and meals. Feeding locations closest to your patients can be found here: <https://solvehungertoday.org/get-help/where-to-get-food/>.
- **Common Pantry** is offering food delivery for homebound seniors in Chicago. Once per month, volunteers pack bags and deliver food. The service area extends east-west from Ashland Avenue to Kimball Avenue and north-south from Lawrence Avenue to Diversey Parkway. To inquire about receiving this service, call the program manager at 773-327-0553; also visit <http://www.commonpantry.org/emergency-food/> for more information.

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Enrollment – BCCHP

Can a member switch plans at this time?

Members who are in their open enrollment period can switch plans. Maximus, the Illinois Client Enrollment Broker was temporarily closed from March 19 through April 6, 2020, and was not taking any calls. Members and potential members who wanted to make a Managed Care Organization (MCO) selection during that time can now call to make the selection.

Has Illinois Department of Healthcare and Family Services (HFS) done anything to ensure members do not lose eligibility?

HFS has turned off the automated process for any members who cannot complete their redetermination paperwork by the deadline so that Medicaid recipients do not lose eligibility. This will resume after the Public Health Emergency has ended so it is important that members still complete their redetermination paperwork.

Telehealth – BCCHP

Are telehealth and telehealth services available to BCCHP members?

Yes, BCBSIL is covering medically necessary telehealth, telehealth, virtual check-ins and portal visits with Medicaid participating healthcare providers. As with all BCCHP medically necessary covered services, telehealth, telehealth, virtual check-ins and portal visits do not require a co-pay or deductibles.

The following Medicaid participating providers can bill for telehealth services:

- Physicians, advanced practice nurses, physician assistants
- Hospitals
- Federally Qualified Health Center (FQHC)
- Community Mental Health Centers and Behavioral Health Clinics
- Licensed clinical psychologist (LCP)
- Licensed clinical social worker (LCSW)
- Advanced practice registered nurse certified in psychiatric and mental health nursing
- School-based health centers
- Local education agency
- Speech, occupational and physical therapists
- Dentists

The following Medicaid participating providers can bill for virtual check-ins and portal visits

- Physicians
- Advanced practice nurses
- Physician assistants
- FQHCs and Rural Health Clinics (RHCs)
- School-Based Health Centers
- Local health departments

What is the difference between telehealth, virtual check-ins and portal visits?

Telehealth visits are appointments with a qualifying medical professional that are conducted virtually through telephone or video conferencing, or other methods allowed by state and federal law, that typically last for 30 minutes to 1 hour. Virtual check-ins are brief 5-10 minute discussions with a qualifying medical professional that has an established relationship with the patient. Portal visits may be conducted through a provider's patient portal or secure chat messaging with a qualifying medical professional that that has an established relationship with the patient.

How are the new telehealth benefits different from the existing telehealth benefit?

The existing telehealth benefit has been expanded. This means that that more types of providers can deliver services as the originating site and distant site providers. Originating sites are where the member can be when the service is delivered, while distant site providers deliver the service. Providers at distant sites can deliver services in line with their normal scope of billable services from their respective fee schedules.

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Below is the full list of providers who can now serve as **originating sites**:

- Physician office
- FQHC, RHC, or Encounter Rate Clinic (ERC)
- Community Mental Health Centers
- Substance Abuse Centers licensed by the Illinois Department of Human Services Division of Substance Use Prevention and Recovery (SUPR)
- Supportive Living Program providers
- Hospice providers
- Community Living Integrated Living (CILA) providers
- Providers who receive reimbursement for a patient's room and board, including:
 - Nursing facilities
 - Intermediate Care Facilities for the Developmentally Disabled
 - Hospitals
 - Family Support Program residential providers
 - Psychiatric Residential Treatment Facilities
 - Medically Complex Facilities for Persons with Developmental Disabilities
 - Specialized Mental Health Rehabilitation Facilities

Note: A member can receive telehealth in their home, but there would be no originating site in this instance.

Below is the full list of providers who can now serve as **distant sites**:

- Licensed practitioners (may be licensed in any state) registered in IMPACT
- FQHC as defined in Section 1905(l)(2)(B) of the federal Social Security Act
- RHCs or ERCs
- Community Health Agencies
- Community Mental Health Centers or Behavioral Health Clinics
- Agencies licensed by the Division of Substance Use Disorder and Prevention (SUPR)
- Hospitals as defined in Ill Adm 148.25
- LCPs
- LCSWs
- Advanced practice registered nurses certified in psychiatric and mental health nursing
- School-Based Health Centers as defined in 77 Ill Adm. Code, 641.10
- Local health departments
- Physical, speech, or occupational therapists as defined in Ill Adm 140.457
- Licensed dentists
- Audiologists

Do telehealth visits require a prior authorization?

Services do not require prior authorization just because they are delivered via telehealth. If the procedure or service being done normally requires prior authorization, then prior authorization is still required.

Please note that some services currently have authorizations waived. Please reference the **Prior Authorization – BCCHP** information below for the COVID-19 authorization waivers.

Can only in-network providers bill telehealth?

No, any Medicaid participating provider can bill telehealth.

Can providers do telehealth via Skype, Zoom or FaceTime?

Yes.

How does a provider bill for telehealth, virtual check-ins or portal visits for BCCHP members?

Providers should refer to the Illinois Association of Medicaid Health Plans (IAMHP) billing guidance posted on the [IAMHP website](#).

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Do providers need to contract with BCBSIL for telehealth services to bill telehealth services for BCCHP members?

No, any qualifying, Medicaid-participating providers can bill for telehealth using appropriate billing code for the telehealth service rendered. Providers should check the [IAMHP website](#) for billing guidance to determine if they are a qualifying provider type.

What rates does BCBSIL pay for telehealth services for BCCHP members?

BCBSIL pays the published Medicaid rates for telehealth, virtual check-ins and portal visits with Medicaid participating providers. Providers should refer to the HFS website for rate information.

Can all provider types provide telehealth to a BCCHP member at home?

Yes, in this circumstance only the distant site claim would be received and payable.

If a BCCHP member calls their PCP and the PCP is not offering telehealth, where should the member find telehealth providers?

Members may use the [Provider Finder®](#) on our website to identify alternative providers.

Care Coordination – BCCHP

Is BCBSIL conducting outreach to our high-risk BCCHP members at this time?

Yes, our care coordinators are contacting high-risk populations first such as the elderly (>80 years), long term care facilities, members with chronic conditions (heart, kidney, diabetes), members who receive Home and Community-Based Services (HCBS) waivers and members with compromised immune systems. Care coordinators will document answers to questions within specific COVID-19 member documentation to determine member support needs and provide education to ensure members are well versed in prevention strategies, COVID-19 symptoms, etc. If further screening is deemed necessary, the care coordinator will do so.

Are service coordinators conducting face-to-face visits for BCCHP members?

No, BCCHP teams have suspended care coordination face-to-face visits through May 30, 2020, in light of the COVID-19 crisis. Assessments and required activities including Interdisciplinary Care Team (ICT) meetings will continue over the phone.

What should a BCCHP member do if they need to reach care coordination?

For help with community resources, food, in-home services and other specialized needs, BCCHP members can call our care coordination hotline at 855-334-4780.

Prior Authorization – BCCHP

Is BCBSIL still requiring prior authorization for medical services?

Effective March 1, 2020, HFS announced that the services listed below will not require prior authorization. BCBSIL will be following the HFS directive and relaxing prior authorization requirements for these services as well. **The full list of codes can be found on the [HFS website](#).**

- Physical, occupational, and speech therapies
- Home health
- Certain durable medical equipment and supplies

In addition to the specific services above no longer requiring prior authorization, BCCHP plans are following BCBSIL's updated policies for COVID-19 prior authorizations. as posted in the [News and Updates section](#) of our Provider website.

To help support expedited hospital discharges to increase availability of hospital beds, any hospitals wishing to transfer BCCHP members to an in-network alternative site of care from an acute setting may do so without first obtaining a prior authorization. The receiving post-acute site of care is required to notify BCBSIL the following business day after receiving the member and must provide clinical documentation, as the medical necessity review will happen at that time. (See the [News and Updates](#) notice for details.)

For BCCHP member inpatient admissions, we are requiring that providers notify BCBSIL of the inpatient admission so that we can appropriately coordinate care, assist with discharge planning and help our members with a safe placement following their stay. BCBSIL will not pay for any services that are not medically necessary.

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Is BCBSIL extending prior authorizations that were obtained prior to the Public Health Emergency that will expire?

Prior authorizations that were previously approved and had an expiration date will be extended to Dec. 31, 2020, so that providers do not need to get new prior authorizations. While prior authorization expiration dates will be extended, if additional services are needed, the provider must request a new prior authorization. Prior authorization is not a guarantee of payment.

Is BCBSIL still requiring authorizations for Home and Community-Based Services (HCBS) services?

Members must have all HCBS services documented in their care plans. BCBSIL will not cover member overages of allocated service plan hours. If members need more hours, it must be documented in the care plan by the care coordinator for coverage. HFS has allowed Department of Human Services-Division of Rehabilitation Services (DHS-DRS) and Department on Aging (DoA) flexibility in Determination of Need (DON) assessments to be completed telephonically so members who are needing to initiate services can still receive an assessment.

Claims and Provider Payments – BCCHP

Is BCBSIL still making provider payments and processing claims?

Yes, the claims processing centers remain open. Generally, BCBSIL is processing claims and making payments in less than 30 days.

Is BCBSIL paying providers for the new COVID-19 tests?

For BCCHP members: HFS has added several new codes to the fee schedules, and BCBSIL will be paying all of the codes that HFS has added to the fee schedules at the same rates. The provider does not need to contact BCBSIL in order to bill these codes.

Have the BCBSIL claims systems been updated with the new COVID-19 testing codes, diagnosis codes, telehealth codes, etc.?

We are actively working to update the claims system. Any claims submitted prior to the system updates that may have been denied inaccurately or paid at the incorrect rate will be reprocessed as soon as the configuration is complete. Providers do not need to call customer service or request reprocessing projects for this. All claims will be identified based on the billing codes and diagnosis codes.

Is BCBSIL waiving timely filing for claims payments?

BCCHP claims currently have a 180-day timely filing limit. We will continue to evaluate extension of the time frame for submission of claims that would have exceeded the 180-day timely filing deadline during this COVID-19 Public Health Emergency.

What should providers do if they submitted a claim with the incorrect billing codes prior to receiving final billing guidance?

The claim should be corrected and resubmitted.

What is the Illinois Medicaid 1135 waiver?

The 1135 waiver is a list of “flexibilities” that HFS has requested from CMS. Some of these flexibilities would allow HFS and MCOs to temporarily lift or suspend certain requirements to ensure that our members are able to access appropriate and timely medical care during this COVID-19 Public Health Emergency.

What does the 1135 waiver include?

The 1135 includes many flexibilities that impact BCCHP members, some of which are listed below:

- State Fair Hearing Requests and Appeals – Flexibility in timelines for scheduling Medicaid Fair Hearing and deciding appeals; Waive requirement of Appointment of Representative (AOR) and extend appeal filing timelines
- Benefits – Addition of telehealth flexibilities
- Pharmacy – Allow refill overrides, coverage of certain non-formulary medications in case of shortages
- Authorizations – Extension of certain authorizations and authorization flexibilities for certain services;
- Claims – Allow payment in new place of service types, reimbursement for new benefits
- Provider Enrollment – Allows HFS flexibility in provider enrollment requirements, including out-of-state provider enrollment requirements

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Has BCBSIL implemented the 1135 waivers?

All 1135 waivers that have a member impact such as pharmacy refills, telehealth access and COVID-19 testing have all been implemented. Updates to the configuration of the claims system are in progress.

COVID-19 Testing for Medicare Members

Does BCBSIL 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 BCBSIL for approval to test for COVID-19. Testing must be medically appropriate and in accordance with generally consistent medical standards.

Does BCBSIL 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.

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 BCBSIL, that contracted reimbursement rate may apply.

COVID-19 Treatment for Medicare Members

Does BCBSIL 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 Oct. 23, 2020** (previously Aug. 31, 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 [Avality Provider Portal](#) or their preferred vendor to confirm member coverage and benefits. However, to verify telehealth coverage for Medicare Advantage members, call Provider Services at 877-774-8592 and speak with a Customer Advocate. For MMAI members, call 877-723-7702.

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

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

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 and MMAI 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 BCBSIL 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, BCBSIL is suspending the two percent sequestration reduction in Medicare claims payments. This applies to Medicare providers who provide care and service to our Medicare Advantage and MMAI members.

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Due to COVID-19, will BCBSIL 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, call Provider Services.

Telehealth for Medicare Members

Has BCBSIL expanded access to telehealth 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 telehealth may vary. Members should call the number on their ID card if they have questions.

This cost-share waiver for telehealth services applies to claims beginning March 1, 2020 and is scheduled to end Dec. 31, 2020. We are continuing to evaluate the evolving landscape relating to COVID-19 and will update our practices accordingly.

Which providers may provide telehealth services to Medicare members?

Providers of telehealth 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's [telehealth guidance](#) and [Waivers and Flexibilities](#) for more details.

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 telehealth?

Initial and subsequent Annual Wellness Visits (G0438 and G0439) may be conducted by telehealth. Submit claims for wellness visits with Modifier 95 and Place of Service (POS) 11. BCBSIL 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 telehealth visits related to COVID-19?

Telehealth 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.

How can telehealth 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](#).

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How should I code telehealth claims?

BCBSIL will reimburse providers for medically necessary services delivered via telehealth 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 telehealth code, the modifier 95 is not necessary. Only codes that are not traditional telehealth codes require the modifier.

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

How will I be reimbursed for telehealth claims?

Telehealth 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 BCBSIL helping with prescriptions?

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

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

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

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11. HELPFUL EXTERNAL LINKS

CDC

- General: <https://www.cdc.gov/nCoV>
- Healthcare Professionals: <https://www.cdc.gov/coronavirus/2019-nCoV/guidance-hcp.html>
- Information for Laboratories: <https://www.cdc.gov/coronavirus/2019-ncov/lab/>
- Laboratory Biosafety: <https://www.cdc.gov/coronavirus/2019-nCoV/lab/lab-biosafety-guidelines.html>
- Isolation Precautions in Healthcare Settings: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html>
- Specimen Collection: <https://www.cdc.gov/coronavirus/2019-nCoV/lab/guidelines-clinical-specimens.html>

CMS

- Coronavirus (COVID-19) Partner Toolkit: <https://www.cms.gov/outreach-education/partner-resources/coronavirus-covid-19-partner-toolkit>

U.S. Food and Drug Administration (FDA)

- General: www.fda.gov/novelcoronavirus
- Emergency Use Authorizations (EUAs): <https://www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations>

City of Chicago

- <https://www.chicago.gov/city/en/sites/covid-19/home.html>

Illinois Department of Human Services:

- <https://www.illinois.gov/hfs/Pages/coronavirus.aspx>

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12. BCBSIL RESOURCES

[BCBSIL Provider website](#)

- [COVID-Preparedness page](#)
- [COVID-19 Related News](#)
- [COVID-19 Important Dates and Reminders](#)
- [News and Updates](#)
- [Blue Review](#)

Other Announcements

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