BlueCross BlueShield of Texas

COVID-19: Texas Provider FAQs

Updated 8/25/2021 | Posted 4/16/2020

We are continuing to monitor the evolving landscape relating to COVID-19 and will update the FAQ as new information becomes available. We also provide responses to COVID-19 information as it becomes available on our COVID-19 provider website and on our COVID-19 Related News section.

Sections available on this FAQ:

- COVID-19 Testing
- COVID-19 Treatment
- Telehealth
- More Resources

COVID-19 Testing

Which health plans does the waiver of out-of-pocket costs for COVID-19 testing and services to administer testing apply to?

The Families First Coronavirus Response Act (FFCRA), which became effective March 18, 2020, requires health plans to provide coverage (FFCRA coverage) for COVID-19 testing and services to administer testing. This will remain in effect until the public health emergency is declared over by the federal government. An in-network office visit (including either in-person or via telehealth), urgent care visit, or emergency room that results in the order for or the administration of a COVID-19 test will be covered at no cost-share to the member as part of FFCRA.

Does the waiver of cost-share apply only to COVID-19 tests or will it also apply to flu or pneumonia tests a doctor might order to reach a diagnosis?

It applies to COVID-19 tests and those items or in-network services such as an influenza test or other diagnostic tests during a testing-related visit that results in the order for or administration of the test. The items and services must be related to the evaluation of an individual to determination the need for the test or the furnishing or administration of the test.

How do I bill for drive-thru testing when there is no physician's order?

For a service to be covered, testing must be medically necessary and medically appropriate, in accordance with accepted standards of current medical practice, and at the direction of a physician. Some guidance relating to billing codes is available on our COVID-19 provider website.

There are multiple HCPCS codes and a CPT code for the COVID-19 test kit. What code is BCBSTX looking for on claims?

The provider submitting the claim is responsible for accurately coding the service performed. We are accepting U0002 or 87635 (effective 3/13/2020) and 86318, 86328, and 86769 (effective 04/10/2020) on claims. Additional guidance relating to billing codes is available on our COVID-19 provider website.

What is the amount of reimbursement that CMS has approved for the COVID-19 testing for HCPCS code U0002 and CPT code 87635?

The reimbursement amount for HCPCS U0002 and CPT 87635 is $51.33.
This amount can be found on the CMS website.

If a member does not have telemedicine as part of their policy, can they receive telehealth services during this time?

State regulated, fully-insured members, Medicare (excluding Part D plans) and Medicare Supplement members can access provider visits for covered services as outlined in their benefit plan through telemedicine or telehealth. They won't pay copays, deductibles, or coinsurance on in-network covered telemedicine or telehealth services. Our self-funded employer group customers make decisions for their employee benefit plans. For some employer groups, telehealth services not related to COVID-19 diagnostic testing are subject to the member's benefit plan. For more information, including dates when waiver of cost-shares for in-network visits will end, refer to our telemedicine/telehealth response.

Does waiving cost-share related to COVID testing/screening mean BCBSTX will not apply cost-sharing when processing the claim?

Yes, we will not apply the cost-sharing when processing the claim related to COVID-testing/screening.

Are employer-funded health plans required to provide coverage for COVID-19 testing?

Effective March 18, 2020, The Families First Coronavirus Response Act (FFCRA) requires employer-funded health plans to provide coverage for COVID-19 testing and testing-related visits. Some benefits, beyond COVID-19 testing coverage, may be different depending on the decisions the employer makes about expanding telehealth services at no-cost share to members.

How much will providers be reimbursed for the diagnostic testing?

The Centers for Medicare and Medicaid Services (CMS) has set the price for the COVID-19 diagnostic tests at $51.33 for U0002 and 87635. We will follow CMS pricing and apply the terms of our contracts.

How should providers direct members for testing?

Members should be directed to contact their physician for guidance on testing. They can also visit Centers for Disease Control and Prevention (CDC) website for the latest information on testing.

Where can I send patients for COVID-19 testing?

If available, you can complete COVID-19 tests in your office and send the specimens to our participating labs for results. In addition, providers can refer members to various testing sites around Texas.

Members can get tested for COVID-19 at drive thru locations in certain parts of Texas.

A list of the drive-thru testing sites is available on Texas Department of State Health Services (TDSHS). These testing sites are not run or overseen by TDSHS. Information is only accurate at the time the list is posted. Please check the TDSHS website for most current information.

Which labs do providers need to use for testing?

BCBSTX contracted providers are encouraged to use in-network labs. For more info, go here.

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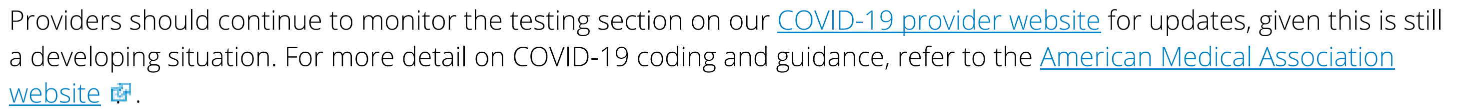
What are the requirements for specimen collection?

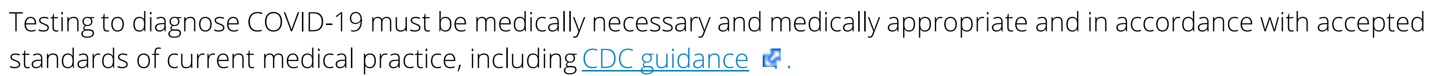
See the CDC guidance for the latest information on testing.

How should providers code COVID-19 testing claims?



Providers should continue to monitor the testing section on our COVID-19 provider website for updates, given this is still a developing situation. For more detail on COVID-19 coding and guidance, refer to the American Medical Association website.

If someone is not exhibiting symptoms for COVID-19, but wants to be pro-actively tested, will it be covered or are there restrictions?



Testing to diagnose COVID-19 must be medically necessary and medically appropriate and in accordance with accepted standards of current medical practice, including CDC guidance.

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COVID-19 Treatment

Will BCBSTX cover PHP and IOP services delivered via telemedicine/telehealth?

For in-network providers, PHP and IOP services will be temporarily allowed to be delivered by telehealth for our fully insured members if the other coverage criteria in the benefit plan is met. The provider submitting the claim is responsible for accurately coding the service performed. Providers can bill for those services using the appropriate HCPCS codes (e.g., H0035 and S0201 for PHP and H0015 and S9480 for IOP) and attach the 95 modifier when delivering these services via telehealth.

If a member who just returned from a Level 3 COVID-19 foreign country contacts a provider for medical guidance, how should providers proceed?

Questions about the COVID-19 travel guidelines should be directed to the CDC.

CMS is expediting Medicare enrollment for providers. Does BCBSTX plan on expediting credentialing?

We have updated our credentialing policy and processes in response to the COVID-19 emergency. See the latest information on Credentialing on the COVID-19 provider website.

Will you cover treatment for COVID-19?

BCBSTX will waive member cost-sharing, including deductibles, copayments and coinsurance related to treatment for COVID-19. The waiver applies to costs associated with COVID-19 treatment at in-network facilities and treatment for out-of-network emergency room or office visit emergency treatment. Our self-funded employer group customers make decisions for their employee benefit plans. For some employer groups, treatment for COVID-19 is subject to the member's benefit plan.

How should I code COVID-19 claims for treatment?

Follow the appropriate CDC guidance on diagnosis coding for the date of service. The CDC has provided interim coding guidance on which ICD-10 diagnosis codes to report until a new code becomes effective Oct. 1, 2020.

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

Physician home visits will be covered as indicated by the member's medical benefits.

Do you anticipate a delay in claims processing and payment?

We do not expect delays in claim processing and payment.

Will there be a dedicated COVID-19 hotline?

Not at this time. Members should call the number on their member ID card to reach a customer advocate. Providers should contact their BCBSTX Network Management Representative.

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

While eligibility and benefits information for most members/services can be obtained by submitting an electronic 270 transaction, telehealth-specific services are not in the electronic eligibility and benefits response. Also, telemedicine/telehealth benefits are not available in our automated Interactive Voice Response (IVR) phone system. For telemedicine/telehealth benefits, please call our Provider Customer Service at 1-800-451-0287 (4/23/20: Updated incorrect phone number).

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Can licensed clinicians conduct telemedicine 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 telemedicine.

Will BCBSTX be extending the timely claims filing requirements?

At this time BCBSTX will not be extending the timely claims filing requirements. Current requirements for in-network providers can be found in the Provider Manuals located on the BCBSTX website.

- PPO Claims Filing Deadlines: BCBSTX asks that providers file all claims as soon as possible but no later than 365 days from the date of service or date of discharge for in-patient stays or according to the language in the subscriber/provider contract. Corrected claims must be filed with the appropriate bill type and filed according to the claims filing deadline as listed above or in the subscriber's contract.
- Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Claims Submission Timely Claims Filing Procedures: The Plan claims must be submitted within 180 days of the date of service. Plan health care providers must submit a complete claim for any services provided to a member. Claims that are not submitted within 180 days from the date of service are not eligible for reimbursement. Claims submitted after the designated cut-off date will be denied on a Provider Claim Summary (PCS).
- STAR Kids, STAR and CHIP Claims Filing Deadline: All claims must be submitted within the contracted filing limit to be considered for payment. We will deny claims that are received past the filing limit. The time limit to file is within 95 days of date of service.
- Medicare Advantage HMO Claims filing Deadline: The time limit to file is within is 180 days of the date of service.
- Medicare Advantage PPO Claims Filing Deadline: The time limit to file is within is 90 days of the date of service.

Will BCBSTX be extending prior authorizations obtained on previously-approved elective surgeries, procedures, and therapies?

Blue Cross and Blue Shield of Texas (BCBSTX) is 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 and June 30, 2020 (previously April 1, 2020). This is for most non-emergent, elective surgeries, procedures, therapies and home visits. See the posting here for further details.

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Telehealth

Is BCBSTX going to cover telemedicine services provided by PT, OT, ST, Home Health and Dietitians?

Telehealth claims for insured members submitted by physical therapy, occupational therapy, and speech therapy providers, home health and dietitians in accordance with appropriate coding guidelines, including appropriate modifiers, for in-network medically necessary health care services will be covered without cost-sharing and will be reimbursed at parity with in-person office visits.

Should I bill services with a 'T' at the end of the CPT/HCPCS code. Is this something that is required from BCBSTX?

BCBSTX is not expecting to see the letter "T" at the end of the code. Billing guidance on our website explains that telemedicine/telehealth services should be billed with the appropriate CPT/HCPCS code and modifier 95.

What are the codes I can bill, and will they require the Place of Service (POS) code and modifiers applicable to telehealth services?

The provider submitting the claim is responsible for accurately coding the service performed. Please refer to the telemedicine/telehealth response on our website for some information relating to billing.

Are telemedicine/telehealth consultations covered? Is there an end date?

The coverages below will temporarily apply for state regulated, fully-insured members who receive covered telemedicine/telehealth services. This applies to claims with dates of service beginning March 10, 2020:

- Telemedicine/telehealth visits covered as a regular office visit for providers who offer the service through 2- way live interactive telephone or digital video consultations. Please note that on a temporary basis in response to COVID-19, audio-only consultations will be covered when provided in accordance with applicable regulations and rules.
- Continued access to MDLIVE or a similar telemedicine/telehealth vendor, with a network of physicians who provide telemedicine/telehealth services.
- No member cost-sharing for covered, medically necessary medical and behavioral health services delivered via telemedicine or telehealth by a qualified in-network provider.
- BCBSTX will reimburse in-network professionals at least the same rate for a telemedicine/telehealth service as it reimburses for the same service when provided in- person, including covered mental health services.

More information about our expanded coverage is available here under Telemedicine and Telehealth. Our state-regulated fully insured HMO and PPO members access through Dec. 31, 2020. Our Medicare members have access through the end of the HHS public health emergency. Providers should continue to monitor our website for updates, given this is still a developing situation.

Are telemedicine/telehealth visits limited to COVID-19 diagnosis code (or with the COVID-19 modifier)?

No, telemedicine/telehealth visits may be provided for medically necessary covered services. Please submit claims for the approved telemedicine/telehealth codes using the modifier 95 and POS 02.

Do providers have to use our telemedicine/telehealth vendor?

No. For state funded fully insured members, providers may use 2-way live interactive telephone or digital video consultations. Please note that on a temporary basis in response to COVID-19, audio-only consultations will be covered when provided in accordance with applicable regulations and rules. For self-funded members, providers may be required to use specific telemedicine/telehealth vendors as outlined in the member's benefit plan.

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Are telehealth visits provided over the telephone covered?

Coverage for telephone-only consultations is available on a temporary basis for state-regulated plans, which can be identified by the letters TDI or DOI on the front of the insurance ID card.

How are telehealth visits being covered by ERS?

- MDLIVE and Doctor On Demand visits are covered with zero cost share to ERS enrollees.
- Provider telemedicine visits associated with COVID-19 diagnosis are covered with zero cost share to ERS enrollees. This went into effect March 6, 2020 for HealthSelect plans, except for the Consumer Directed HealthSelect plan which became effective March 11, 2020, compliant with IRS regulations.

What documentation should be included in telehealth visits?

See the Texas Medical Board FAQs on Telemedicine "What are the requirements for documenting a telemedicine visit".

Is telehealth available for Medicare Advantage plan members?

Yes, consistent with CMS' new ruling.

Is telehealth available for Medicaid members?

Yes. Please visit the Medicaid News Alerts for more information.

More Resources

Revised: 08252021

CDC webpages:

- 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/guidance-laboratories.html
- Laboratory Biosafety: https://www.cdc.gov/coronavirus/2019- nCoV/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/guidelines-clinical-specimens.html

FDA webpages:

- General: www.fda.gov/novelcoronavirus
- EUAs: https://www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations

Texas Department of State Health Services (DSHS)

- General: https://www.dshs.texas.gov/coronavirus/

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As a reminder, it is important to check eligibility and benefits before rendering services. This step will help you determine if benefit prior authorization is required for a member. For additional information, such as definitions and links to helpful resources, refer to the Eligibility and Benefits section on BCBSTX's provider website.

Please note that checking eligibility and benefits, and/or the fact that a service or treatment has been prior authorized or predetermined for benefits 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 questions, contact the number on the member's ID card.

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