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TEMPORARY/EMERGENCY CORPORATE PAYMENT POLICY 30: WAIVER OF COST SHARE FOR COVID-19-RELATED TESTING, DIAGNOSIS, AND INPATIENT TREATMENT
Updated Effective April 1, 2023

Original Effective Date: March 13, 2020
Expiration Date: May 11, 2023

Description

This payment policy was implemented on a temporary/emergency basis. **This policy will expire on May 11, 2023, to align with the end of the Public Health Emergency.**

The purpose is to remove barriers to Blue Cross and Blue Shield of Vermont (Blue Cross VT) members receiving care and accessing testing during the COVID-19 pandemic.

Blue Cross VT reserves the right to implement, modify, and revoke this policy without the contractual sixty-day (60) notification for a change in policy that is normally required in provider contracts. This will apply for both the effective date, due to the urgent and emergent nature of the pandemic, as well as changes to and for withdrawal of the policy. Notice of changes to this policy will be communicated to providers via a notice on Blue Cross VT's provider website.

This policy applies to Blue Cross VT fully-insured plans. Self-insured plans may opt to waive cost sharing. This policy does not apply to services provided to members of other Blue Plans or to FEP members.

Policy

On a temporary/emergency basis, Blue Cross VT will waive member cost-sharing for office visits related to COVID-19 screening and testing, subject to the following limitations:

- For symptomatic individuals or individuals with a known or suspected exposure to COVID-19, cost share will be waived for the office, telemedicine, urgent care, or ER visit related to the screening and testing where the claim utilizes either of the following diagnosis codes as the primary diagnosis (first position on the claim form):
    - Prior to October 23, 2020: Z03.818 or Z20.828
    - October 23, 2020 through December 31, 2020: Z20.828 or U07.1
    - January 1, 2021 forward: Z20.822 or U07.1.

- For asymptomatic individuals:
    - For claims submitted January 1, 2021, and forward, Z11.52 should be utilized. Cost share will be waived for the test but not for the associated office, telemedicine, urgent care, or ER visit.
    - For claims submitted between October 23, 2020, through December 31, 2020, Z11.59 should be utilized. Cost share will be waived for the test but not for the associated office, telemedicine, urgent care, or ER visit.

- For claims submitted prior to October 23, 2020,
  - If the primary reason for the visit is for COVID-19 screening, and the claim is billed with diagnosis code Z11.59 as the primary diagnosis (first position on the claim form), cost share will be waived for both the test and the visit. Cost share will apply for any other associated procedures or other lines on the claim form.
  - If the primary reason for the visit is NOT for COVID-19 screening, and diagnosis code Z11.59 is billed as something other than the primary diagnosis (a position other than the first position on the claim form), cost share will be waived for the test but NOT the visit.

To support the added burden COVID-19 screening creates for independent practices, Blue Cross VT will waive cost share, for claims by independent primary care practices only, for CPT® 99001, as follows:

(a) For claims submitted on or after October 23, 2020, through December 31, 2020, if CPT® 99001 is billed with diagnosis code Z20.828, U07.1, or Z11.59, and
(b) For claims submitted on January 1, 2021, or later, if CPT® 99001 is billed with diagnosis code Z20.822 or Z11.52 or U07.1.

For claims submitted on or after October 23, 2020, CPT® 99072 will be treated as inclusive to the office visit and will not be eligible for separate payment.

On a temporary/emergency basis, Blue Cross VT will waive member cost-sharing for COVID-19 treatment in the inpatient setting for admissions through March 31, 2023; this includes both the facility and professional services (UB-04 or CMS-1500 form types), billed with a primary ICD-10-CM diagnosis codes of COVID-19 (U07.1 for claims after April 1, 2020 or B97.29 for claims prior to April 1, 2020).

Provider Billing Guidelines and Documentation

I. Billing for COVID-19 Screening and Testing

a. General

- Physicians or other qualified health care professionals should follow the guidance from the Centers for Disease Control (CDC) and the Vermont Department of Financial Regulation with respect to billing for COVID-19 testing.
- Testing/screening services must be provided in an office (place of service 11), or urgent care center (place of service 20) or emergency room (place of service 23) setting, or via telemedicine (place of service 02).
- If a practice is doing the interactions/testing in a parking lot/driveway, bill using the appropriate place of service (POS), as follows: POS 11 for office property, POS 20 for urgent care clinic property, and POS 23 for Emergency Room property.
- If the interaction/testing is being provided in another location (for example a tent in a shopping plaza), submit using POS 20.

- The ICD-10-CM code B97.29 (Other coronavirus as the cause of diseases classified elsewhere) (for claims prior to April 1, 2020) or U07.1 (for claims April 1, 2020, forward) should be reserved for patients with confirmed coronavirus and therefore, should not be used for the purposes of screening.

b. Symptomatic vs. Asymptomatic Screening

	Symptomatic or Suspected/Known Exposure	Asymptomatic; Primary Reason for Visit = Screening	Asymptomatic; Primary Reason for Visit is NOT for Screening
Zero Cost Share for Test?	Yes	Yes	Yes
Zero Cost Share for Visit?	Yes	Yes, for claims submitted before October 23, 2020. No, for claims submitted October 23, 2020, and after.	No
Appropriate ICD-10-M Code as Primary Dx	For claims submitted prior to October 23, 2020: Z03.818 Encounter for observation for suspected exposure to other biological agents ruled out OR Z20.828 Contact with an (suspected) exposure to other viral communicable diseases For claims submitted between October 23, 2020, and December 31, 2020: U07.1 OR Z20.828 Contact with an (suspected) exposure to other viral communicable diseases For claims submitted after January 1, 2021: U07.1 OR Z20.822 Contact with and suspected exposure to COVID-19	For claims submitted prior to October 23, 2020: Z11.59 (Encounter for screening for other viral disease) For claims submitted after January 1, 2021: Z11.52	Primary diagnosis code should correspond to the primary reason for the visit. For dates of service prior to January 1, 2021, Z11.59 may be billed as something other than the primary diagnosis. For dates of service January 1, 2021, or after, Z11.52 may be billed as something other than the primary diagnosis.

II. Billing for COVID-19 Hospital Inpatient Treatment

For admissions beginning prior to March 31, 2023, Blue Cross VT is waiving out-of-pocket costs for COVID-19 inpatient treatment. The term “inpatient treatment”:

- Refers to hospital inpatient services that are supportive in nature, focused on symptom relief for the acute illness, and billed on the inpatient claim; and
- Does not apply to any related services provided in a non-inpatient setting; and
- Is limited to services provided during the emergency period (defined as an admission date from March 13, 2020, through March 31, 2023, with a primary ICD- 10-CM diagnosis code of U07.1 (or B97.29 for claims prior to April 1, 2020).

Physicians and other qualified health care professionals must follow any applicable industry standards for billing these services that may be developed, including any requirements related to DRG billing, diagnosis coding, or CPT®/HCPCS coding or revenue coding.

III. COVID-10 Vaccine Administration

When billing for administration of the COVID-19 vaccine, the appropriate code for the vaccine itself must be reported on the claim. The vaccine code must be reported with no modifier (do not bill with modifier -SL) and a zero charge (or $0.01 if your system cannot accommodate a zero charge).

The administration will be considered for benefits without member liabilities. The vaccine is not currently eligible for reimbursement as it is being supplied by the federal government.

As a reminder, COVID-19 administration and vaccines for Medicare Advantage members (including Vermont Blue Advantage members) must be billed to the original fee-for-service Medicare program.

The codes for the vaccines and administration are listed below:

Code	Effective Date	Description
91300	12/11/20	Pfizer-BioNTech vaccine
91301	12/18/20	Moderna vaccine
91302	Pending FDA Approval/EUA	AstraZeneca vaccine
91303	02/27/21	Janssen (Johnson & Johnson) vaccine
0001A	12/11/20	Pfizer-BioNTech administration, first dose
0002A	12/11/20	Pfizer-BioNTech administration, second dose
0011A	12/18/20	Moderna administration, first dose
0012A	12/18/20	Moderna administration, second dose
0021A	Pending FDA Approval/EUA	AstraZeneca administration, first dose
0022A	Pending FDA Approval/EUA	AstraZeneca administration, second dose

0031A	02/27/21	Janssen (Johnson & Johnson) administration

NOTE: M0201 (effective 6/8/21) (COVID-19 vaccine administration inside a patient's home; reported only once per individual home per date of service when only COVID-19 vaccine administration is performed at the patient's home) is considered informational and does not provide any additional reimbursement. The exception is in the case of individuals with Medicare supplemental policies, in which cases we will consider Medicare-reported patient liabilities.

Policy Implementation/Update Information

This policy was originally implemented on an emergency/temporary basis effective March 13, 2020.

The policy was updated April 22, 2020, to include an additional place of service (telemedicine) and an additional diagnosis code for screening (Z11.59).

The June 11, 2020 update made certain minor changes and extended the end date for the policy.

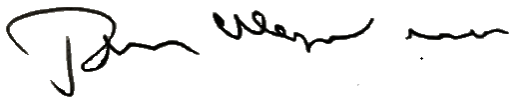
The August 25, 2020 update clarifies the application of cost share when the diagnosis code for asymptomatic patients is utilized.

The November 2020 update extends the end date of the policy and includes references to diagnosis code Z20.822, removes Z11.59, adds information about CPT ®s 99072 and 99001, to align with the requirements of Vermont Department of Financial Regulation (DFR) Regulation H-2020-06-E.

The April 1, 2022 update extends the waiver of cost sharing for inpatient treatment through admissions that began before March 31, 2023.

The April 1, 2023 update extends the policy through May 10, 2023 and expires the policy as of May 11, 2023.

Approved by **Date Approved: March 27, 2023**



Tom Weigel, MD, Chief Medical Officer