COVID-19

Temporary payment policy

MASSACHUSETTS

Policy

Blue Cross Blue Shield of Massachusetts (Blue Cross*) has developed this temporary COVID-19 payment policy to meet the needs of our providers and members during the COVID-19 Department of Public Health (DPH) Public Health Emergency. This policy outlines how Blue Cross reimburses for COVID-19 related services with guidance from the Centers for Disease Control (CDC), the Centers for Medicare & Medicaid Services (CMS), state health departments, American Medical Association (AMA), and other relevant health organizations.

Information in this temporary COVID-19 payment policy supersedes other Blue Cross payment policies for the duration of the Department of Public Health (DPH) Public Health Emergency. Because this situation is fluid and fast-moving, we will continue to update this policy as things change. Please refer to the Policy update history section on the last page to learn more about the most recent updates.

The coding information below is for *informational purposes only*. This may not be a complete list of all the services related to COVID-19. Whether or not a code is listed in this policy does not guarantee coverage or reimbursement.

Blue Cross reserves the right to perform post-payment audits and recover payments retrospectively if found to be inconsistent with Blue Cross policies.

The below sections are available in this policy:

General cost share, referrals & authorization information

Information about waiving cost share, referrals, and authorization can be found on the Blue Cross Provider COVID-19 Information Page.

Reimbursement information

Except as specifically noted below, Blue Cross reimburses health care providers based on your contracted rates and member benefits.

Claims are subject to payment edits, which Blue Cross updates regularly.

Testing for COVID-19

Blue Cross accepts the following codes for COVID-19 testing as outlined in the coding grid below.

The list of codes below is included for *informational purposes only*. This is not a complete list of all the codes related to this service. Whether or not a code is listed here does not guarantee coverage or reimbursement.

Code	Service description	Comments
U0001	CDC 2019 novel coronavirus (2019-ncov) real-time rt-pcr diagnostic panel	Reimbursable for claims with dates of service on or after February 4, 2020

Code	Service description	Comments
U0002	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19) using any technique, multiple types or subtypes (includes all targets), non CDC	Reimbursable for claims with dates of service on or after February 4, 2020.
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	Reimbursable for dates of service on or after March 13, 2020. Do not bill 87635 and U0002 on the same day for the same patient.

Vaccine and vaccine administration codes for COVID-19

Blue Cross will accept the following CPT codes for COVID-19 vaccines and COVID-19 vaccine administration.

- Please submit the vaccine administration procedure code and vaccine/toxoid code on the same claim.
- **For Medicare Advantage plans:**
  - For dates of service before January 1, 2022, submit claims for COVID-19 vaccine and the administration of the vaccine to the CMS Medicare Administrative Contractor (MAC) for payment.
  - For dates of service on or after January 1, 2022, submit claims for COVID-19 vaccine and the administration of the vaccine to the member's plan.

If a vaccine administration service is provided with an Evaluation and Management (E/M) service that:

- Is appended with modifier 25 and is **unrelated** to the vaccine administration service, Blue Cross will reimburse both services.
- Is **not** appended with modifier 25 or appended with modifier 25 and is **related** to vaccine administration service, Blue Cross will deny the evaluation and management service.
- In addition, facilities billing for services rendered in an outpatient clinic setting must submit E/M services on a professional revenue code only.

The list of codes below is included for *informational purposes only*. This may not be a complete list of all the codes related to this service. Whether or not a code is listed here does not guarantee coverage or reimbursement.

Active vaccine and vaccine administration codes reimbursed by Blue Cross:

Code	Description	Comments
90480	**Vaccine Administration** SARSCOV2 VACC 1 DOSE	Reimbursed by Blue Cross effective 9/11/2023
91318	Pfizer-BioNTech COVID-19 Vaccine 2023-2024 Formula (Yellow Cap)	Reimbursed by Blue Cross effective 9/11/2023
91319	**Pfizer-BioNTech** COVID-19 Vaccine 2023-2024 Formula (Blue Cap)	Reimbursed by Blue Cross effective 9/11/2023
91320	**Pfizer-BioNTech** COVID-19 COMIRNATY (COVID-19 Vaccine, mRNA) 2023-2024 Formula	Reimbursed by Blue Cross effective 9/11/2023
91321	Moderna COVID-19 Vaccine 2023-2024 Formula	Reimbursed by Blue Cross effective 9/11/2023
91322	**Moderna** COVID-19 SPIKEVAX 2023-2024 Formula	Reimbursed by Blue Cross effective 9/11/2023
91304	**Novavax** Covid-19 Vaccine, Adjuvanted (Aged 12 years and older)	Reimbursed by Blue Cross effective 10/3/23
M0201	COVID-19 vaccine administration inside a patient's home	Reimbursed by Blue Cross effective 6/8/2021

Pharmaceutical treatment for COVID-19 infection

Blue Cross will accept the following CPT codes for treatment for COVID-19 infection. Since the drugs listed below are supplied free, Blue Cross will not reimburse separately for the drugs regardless of modifier.

For Medicare Advantage plans

- For dates of service before January 1, 2022, submit claims for COVID-19 drug and the administration of the drug to the CMS Medicare Administrative Contractor (MAC) for payment.
- For dates of service on or after January 1, 2022, submit claims for COVID-19 drug and the administration of the drug to the member's plan.

Drive-through, tent, or specimen collection for COVID-19

For dates of service on or after September 1, 2023, Blue Cross will no longer reimburse specimen collection procedure code 99001.

Drive-through (tent) and office visit testing
When testing patients in a drive-through, office or other setting (such as a tent), please use the following codes on claims with dates of service on or after March 1, 2020 through August 31, 2023.

- For specimen collection report one of the following codes*:
  - **99001** for specimen collection; **or**
- Report evaluation and management (E/M) codes when applicable*
- For lab testing codes, see the Testing for COVID-19 section above
- For place of service (POS) code, see Place of Service section below
- **Other specimen collection coding:** Use **G2024*** when applicable: Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source). **Deleted code as of May 11, 2023.**
- Use C9803 when applicable for Medicare Advantage Facility only: Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), any specimen source). Refer to CMS for reimbursement information.

*Specimen collection codes will not be separately reimbursed when reported by the same provider on the same day as an E/M for the same member. This includes face-to-face, telehealth, or telephonic E/M service.

Field hospital billing guidelines

Blue Cross defined terms during the Department of Public Health (DPH) Public Health Emergency
- **Billing hospital**: hospital acting as a billing entity on behalf of the field hospital
- **Field hospital**: nontraditional site

For inpatient care provided at a **field hospital** follow the billing guidelines below:

- For inpatient care referred from a **billing hospital** to its **field hospital**
  - **Billing hospital** bills the entire length of the inpatient stay on one continuous facility claim on behalf of the **field hospital**.
    - This will prevent the **field hospital** inpatient stay from being flagged as a readmission.
- For inpatient care referred to a **field hospital**
  - **Billing hospital** bills for services performed at a **field hospital** as if they were being provided at the billing hospital.
- Report occurrence code 59 on all claims billed on behalf of a **field hospital**
  - Occurrence code 59 should be reported on the 837 in the 2300 loop
  - The occurrence code should be placed in one of the first eight positions
  - Reporting the occurrence code is for informational/tracking purposes only and will not impact reimbursement
- These billing guidelines apply to all products.

Code	Service description	Comments
Occurrence code 59	Reserved for state assignment	• Report occurrence code 59 on all claims billed on behalf of a **field hospital** • Reporting the occurrence code is for informational/tracking purposes only and will not impact reimbursement

Modifier reporting

Modifiers that affect payment must continue to be reported during the COVID-19 Department of Public Health (DPH) Public Health Emergency. For example, the following modifiers must continue to be reported (TC, 26, 59, etc). Please refer to the CPT & HCPCS Modifiers Payment Policy for modifier specific information.

Modifiers below may be reported as part of the COVID-19 Department of Public Health (DPH) Public Health Emergency. They are *informational only* and not required:	
Modifier	**Description**
CR	Catastrophe or disaster related
CS	COVID-19 testing related services

The following modifiers apply to telehealth or telephonic services. Please refer to the Telehealth and telephonic services section for billing guidelines.

Note: Modifiers GT and 95 can be used interchangeably.

Code	Service description	Comments
FQ	The service was furnished using audio-only communication technology	Blue Cross will allow the use of these modifiers on **any** code during the COVID-19 Department of Public Health (DPH) Public Health Emergency
FR	The supervising practitioner was present through two-way, audio/video communication technology	
93	Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System	
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system	
G0	Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke	
GQ	Via asynchronous telecommunications system	
GT	Via interactive audio and video telecommunication systems	

Diagnosis codes for COVID-19

Symptomatic/No diagnosis yet
Use the diagnosis codes below for patients presenting for evaluation of suspected COVID-19.

In accordance with CDC and Department of Public Health (DPH) guidelines, we expect providers to code for COVID-19 testing and treatment, including supportive services for symptoms related to COVID-19 at doctor's offices, emergency rooms, and urgent care centers. Blue Cross will identify patients presenting for evaluation of possible COVID-19 using the below codes:

Diagnosis code	Service description	Comments
Z20.828	Contact with and (suspected) exposure to other viral communicable diseases	Report if the patient is symptomatic or has been exposed to COVID-19
Z20.822	Contact with and (suspected) exposure to COVID-19	Effective January 1, 2021 use in place of Z20.828
Z03.818	Encounter for observation for suspected exposure to other biological agents ruled out	Report if the patient is symptomatic or has been exposed to COVID-19
Z11.59	Encounter for screening for other viral diseases	Report if the patient is asymptomatic and without known COVID-19 contact
Z11.52	Encounter for screening for COVID 19	Effective January 1, 2021 use in place of Z11.59

COVID-19 diagnosis
If your patient has a previously confirmed COVID-19 illness or tests positive for COVID-19, use the codes below.

Diagnosis code	Service description
B97.29	Other coronavirus as the cause of diseases classified elsewhere
B97.21	SARS-associated coronavirus as the cause of diseases classified elsewhere
U07.1	2019-nCOV acute respiratory disease (Effective April 1, 2020)
B342	Coronavirus infection, unspecified

Personal Protective Equipment

Blue Cross does not reimburse providers for personal protective equipment, 99072.

Code	Service Description	Comments
99072	Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency, as defined by law, due to respiratory-transmitted infectious disease	Not reimbursed

E/M documentation requirements via telehealth/telephone

Blue Cross is temporarily revising its policy during the COVID-19 Department of Public Health (DPH) Public Health Emergency to specify that the office/outpatient E/M (99202-99215) level selection for E/M services when furnished via **telehealth or telephone** can be based on medical decision making (MDM) or time, with time defined as all of the time associated with the E/M on the day of the encounter.

Blue Cross will not require documentation of history and/or physical exam in the medical record.

There is no change to the current standards for medical decision making. Documentation of a telehealth or telephonic E/M service is still required and should include documentation of the medical decision making and the total time spent with the patient used to select the level of E/M.

Face-to-face visits still require the standard documentation for selecting the level of E/M.

Place of service (POS)

For telehealth services in a member's home setting
Consistent with CMS and industry-standard POS reporting guidelines, Blue Cross allows the following POS codes to be submitted:

- POS 02 (telehealth), POS 10 (home) and POS 11 (office). Blue Cross will treat POS 02, POS 10 and POS 11 the same to allow the provider to be reimbursed at the office rate.
- Use of other POS codes may be subject to a facility site of service reimbursement differential.

For telehealth services in a non-home setting
Use the POS code that best describes where the member is located.

- POS 21 (inpatient hospital)
- POS 22/19 (on/off campus outpatient hospital)
- POS 23 (emergency room)
- POS 31 (skilled nursing facility)
- Do not bill the provider's location as the place of service

For audio-only telephonic codes (99441, 99442, 99443, 98966, 98967, 98968)
Report the POS as the location where the provider initiates the call.

For drive-through or other temporary site testing
Use the applicable POS that describes the location of the service.

- POS 11 (office)

- POS 15 (mobile unit)
- POS 20 (Urgent care facility)
- POS 22/19 (On/off campus outpatient hospital)
- POS 23 (emergency room hospital)

Pass through billing/third party services for COVID-19 testing

Providers must report modifier 90 (reference (outside) laboratory) when submitting a claim for a PCR or antigen laboratory test provided by an external laboratory.
Reference: Division of Insurance (DOI) Bulletin 2020-25

Non-emergency ground ambulance transports

For the duration of the Department of Public Health (DPH) Public Health Emergency, Blue Cross will waive pre-authorization requirements for ground ambulance transport by a contracted provider. In addition, ground ambulance transport to and from the locations listed below will be covered to help our healthcare delivery system optimize inpatient capacity.

This applies to in-network, ground ambulance providers for HMO, PPO, Indemnity, Medicare Advantage, and Federal Employee Program* members.

- Excludes air ambulance transport
- Notification is not required
- Cost share is waived for members with a COVID-19 diagnosis
- Cost share will apply for members without a COVID-19 diagnosis

Use one of the following CPT codes: A0426, A0428, A0433, or A0434 (non-emergent transports), and the appropriate modifier shown below to represent the direction of the transfer.

During the COVID-19 Department of Public Health (DPH) Public Health Emergency, Blue Cross will directly reimburse ground ambulance providers for transports rendered to a member during an inpatient stay.

Modifier	Description
DH	Diagnostic site (including COVID-19 testing) or therapeutic site (including dialysis; excluding physician office or hospital) to hospital
EH	Residential, domiciliary, custodial facility (other than skilled nursing facility) if the facility is the beneficiary's home to hospital
HD	Hospital to diagnostic site (including COVID-19 testing) or therapeutic site (including dialysis; excluding physician office or hospital)
HE	Hospital to residential, domiciliary, custodial facility (other than skilled nursing facility) if the facility is the beneficiary's home
HH	Hospital to hospital (includes ASCs approved to provide hospital level of care)
HN	Hospital to alternative site for skilled nursing facility (SNF)
HR	Hospital to residence
NH	Alternative site for SNF to hospital
NN	SNF to SNF
NR*	SNF to residence
PD	Physician office to community mental health center, federally qualified health center, rural health center, urgent care facility, non-provider-based ambulatory surgical center or freestanding emergency center, or location furnishing dialysis services that is not affiliated with an end-stage renal facility
PE*	Physician office to residential, domiciliary, custodial facility (other than skilled nursing) if the facility is the beneficiary's home
PH	Physician office to hospital
PR*	Physician office to home
RH	Residence to hospital
RN*	Residence to SNF

*These modifiers do not currently apply to Federal Employee Program (FEP) members.

Autism services

Effective for dates of service on or after March 16, 2020, the 60 unit per month limit for CPT 97156 (family adaptive treatment guidance administered by the physician or other qualified health professional face-to-face, with guardian(s)/caregiver(s), each 15 minutes) is not applicable for the duration of the COVID-19 Department of Public Health (DPH) Public Health Emergency.

*Existing benefit limits apply for Federal Employee Program (FEP) Blue Focus members.

General Reimbursement Information

Mandated Reimbursement Rates
When Federal, State and/or local laws, regulations or guidance mandate reimbursement rates that are different from contracted rates developed under Blue Cross' standard reimbursement process or methodology, Blue Cross will adopt the mandated reimbursement level without any further adjustments to such rates.

Acute care hospitals

- Medicare Advantage facilities follow CMS guidelines
- Evaluation and management (E/M) services rendered in an outpatient clinic setting must be submitted on a professional revenue code only

When submitting claims, report all services with:

- Up-to-date, industry-standard procedure and diagnosis codes, and
- Modifiers that affect payment in the first modifier field, followed by informational modifiers.

Related policies

Note: Log into Provider Central before clicking Payment Policy links.

Autism Services
COVID-19 Provider Information Page
CPT and HCPCS Modifiers
Frequency
Laboratory and Pathology
Non-Reimbursable Services
Outpatient Clinic Services - Facility
Telehealth (Telemedicine) - Mental Health
Telehealth (Telemedicine) – Medical

Policy update history

04/29/2020	Documentation of policy during COVID-19 Massachusetts State of Emergency
06/01/2020	Addition of reimbursement information for C9803
09/30/2020	Template update; edits for clarity in the Telehealth and Telephonic Codes coding grid, addition of reimbursement information for 99072
10/22/2020	Edited to clarify the "Diagnosis codes for COVID-19" section
12/31/2020	Annual review; updated encounter and contact COVID diagnoses coding information; removed deleted code 99201, revised descriptions for 99202-99205, 99211-99215; addition of reimbursement information for G2250, G2251, G2252, and COVID-19 vaccine and vaccine administration codes: 91300, 91301, 0001A, 0002A, 0011A and 0012A
01/15/2021	Addition of reimbursement information for COVID-19 vaccine and vaccine administration codes; addition of reimbursement information for pharmaceutical treatment for COVID-19 infection; removal of deleted codes G2061-3
02/01/2021	Edits to the following codes effective 4/1/2021: 99441, 99442, 99443, 98966, 96967, 98968, G2250, G2251, G2252, G2012
02/04/2021	Addition of U0005 reimbursement information
02/12/2021	

	Documentation of information on mandated reimbursement rates; inclusion of billing instruction for evaluation and management (E/M) services rendered in an outpatient
03/05/2021	clinic setting
	Addition of reimbursement information for COVID-19 vaccine and vaccine administration codes: 91303 and 0031A; addition of reimbursement information for pharmaceutical treatment for COVID-19 infection codes: Q0245 and M0245
	Removal of pharmaceutical treatment codes Q0239 and M0239 in response to FDA
04/29/2021	revoking the Emergency Use Authorization (EUA) for bamlanivimab when administered alone
	Updates to references of Department of Public Health (DPH) Public Health Emergency
07/29/2021	
09/03/2021	Addition of policy note ("Effective September 2021…") that this policy is temporarily replacing the policies, *Telehealth (Telemedicine) – Behavioral Health* and *Telehealth (Telemedicine) – Medical Services*.
09/30/2021	Addition of reimbursement information for COVID-19 vaccine and vaccine administration codes: 0003A, 0013A and treatment codes Q0240, Q0244
11/19/2021	Addition of vaccine and vaccine administration codes, 91306, 91307, 0004A, 0034A, 0064A, 0071A, 0072A; updated new Medicare Advantage billing guidelines for COVID drugs and vaccines
12/31/2021	Annual coding update: Addition of new telehealth modifiers 93, FQ and FR, and new POS 10
03/25/2022	Addition of vaccine and vaccine administration codes: 0073A, 91305, 0051A, 0052A, 0053A, 0054A; addition of monoclonal antibody codes: Q0220, M0220, and M0221; clarified that the telehealth reimbursement section is effective until 3/31/22, effective 4/1/22 the telehealth guidelines within this document will be replaced by the following updated payment policies: Telehealth (Telemedicine) – Mental Health and Telehealth (Telemedicine) – Medical Services
04/01/2022	Removed the telehealth guidelines from this payment policy; effective 4/1/22 the telehealth guidelines within this document will be replaced by the following updated payment policies: Telehealth (Telemedicine) – Mental Health and Telehealth (Telemedicine) – Medical Services
12/31/2022	Updated Covid-19 vaccine and vaccine administration coding grid
03/31/2023	Revised description of 0134A
06/30/2023	Updated Testing for COVID-19 section to indicate deleted codes; updated Vaccines and Vaccine Administration section to indicate updated descriptions and EUA designations; updated specimen collection section to indicate deleted codes.
08/01/2023	Updated "Drive-through, tent, or specimen collection for COVID-19" section to indicate that specimen collection code 99001 will no longer be reimbursed as of 9/1/23; updated "Vaccine Administration" section to indicate revised EUA designations effective 6/1/23
10/01/2023	Updated "Vaccine and Vaccine Administration" section to indicate deleted codes and new codes
10/20/2023	Updated "Vaccine and Vaccine Administration" section to separate active codes and deleted codes into separate coding grids
12/31/2024	Annual coding update: removed 2023 deleted covid vaccine and admin codes from policy; removed deleted codes G2023, U0003-5
3/31/2025	Removal of covid-19 deleted codes M0245, Q0245 effective 12/13/2023; M0221-M0222, Q0220, Q0240, Q0243-Q0244 effective 12/12/2024; M0243 effective 4/1/2025

This document is for informational purposes only and is not an authorization, an explanation of benefits, or a contract. Receipt of benefits is subject to satisfaction of all terms and conditions of the coverage. Medical technology is constantly changing, and we reserve the right to review and update our policies periodically.

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Payment policies are intended to help providers obtain Blue Cross Blue Shield of Massachusetts' payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy development takes into consideration a variety of factors, including: the terms of the participating provider's contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.