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 Massachusetts public health state of 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 Massachusetts state of 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 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.

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.
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.	Reimbursable for dates of service on or after April 14, 2020. Only to be reported with use of high-throughput technologies. • A high-throughput technology must process more than two hundred specimens a day. • Examples of high-throughput technology include, but are not limited to, the Roche cobas 6800 System, Roche cobas 8800 System, Abbott m2000 System, Hologic Panther Fusion System, GeneXpert Infinity System, and NeuMoDx 288 Molecular.
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.	
U0005	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, CDC or non-CDC, making use of high throughput technologies, completed within 2 calendar days from date of specimen collection (list separately in addition to either HCPCS code U0003 or U0004) as described by CMS-2020-01-R2	Reimbursable for dates of service on or after January 1, 2021 when billed with U0003 or U0004. Diagnostic tests that run on high-throughput technologies completed within two calendar days of the date and time of the specimen collection are eligible for separate reimbursement when billed with add-on code U0005. Do not bill add-on code U0005 for COVID-19 diagnostic tests that don't meet the criteria noted above. These services are not eligible for separate reimbursement. Providers must retain all records to demonstrate compliance with the requirement for billing code U0005.
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. Since the vaccine is supplied free, Blue Cross will not reimburse separately for the vaccine, regardless of the modifier.
- For Medicare Advantage plans, submit claims for COVID-19 vaccine and the administration of the vaccine to the CMS Medicare Administrative Contractor (MAC) for payment.

If a vaccine administration service is provided with an Evaluation and Management 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 evaluation and management (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.

Code	Service description	Comments
91300	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted, for intramuscular use	Effective 12/11/2020 (Pfizer-BioNtech COVID-19 vaccine) Since the vaccine is supplied free, Blue Cross will not reimburse separately for the vaccine, regardless of the modifier.
0001A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; first dose	Effective 12/11/2020 Bill for administration of first dose of CPT 91300 (Pfizer-BioNtech COVID-19 vaccine)
0002A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; second dose	Effective 12/11/2020 Bill for administration of second dose of CPT 91300 (Pfizer-BioNtech COVID-19 vaccine)
91301	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage, for intramuscular use	Effective 12/18/2020 (Moderna-COVID-19 vaccine) Since the vaccine is supplied free, Blue Cross will not reimburse separately for the vaccine, regardless of the modifier.
0011A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; first dose	Effective 12/18/2020 Bill for administration of first dose of CPT 91301 (Moderna-COVID-19 vaccine)
0012A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; second dose	Effective 12/18/2020 Bill for administration of second dose of CPT 91301 (Moderna-COVID-19 vaccine)
91303	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, $5x10^{10}$ viral particles/0.5mL dosage, for intramuscular use	Effective 2/27/2021 (Janssen COVID-19 Vaccine) Since the vaccine is supplied free, Blue Cross will not reimburse separately for the vaccine, regardless of the modifier.
0031A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, $5x10^{10}$ viral particles/0.5mL dosage, single dose	Effective 2/27/2021 Bill for administration of CPT 91303 (Janssen COVID-19 Vaccine)
91302	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, $5x10^{10}$ viral particles/0.5mL dosage, for intramuscular use	Once a COVID-19 vaccine has EUA or approval from the FDA, Blue Cross will accept this vaccine CPT code and administrative codes. (91302 AstraZeneca-COVID-19 vaccine)

0021A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, $5x10^{10}$ viral particles/0.5mL dosage; first dose	Since the vaccine is supplied free, we will not reimburse separately for the vaccine, regardless of the modifier.
0022A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, $5x10^{10}$ viral particles/0.5mL dosage; second dose	

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, submit claims for COVID-19 drug and the administration of the drug to the CMS Medicare Administrative Contractor (MAC) for payment.

Code	Service description	Comments
Q0243	Injection, casirivimab and imdevimab, 2400 mg	Effective 11/21/2020 Drug code not reimbursed regardless of modifier
M0243	Intravenous infusion, casirivimab and imdevimab includes infusion and post administration monitoring	Effective 11/21/2020
Q0245	Injection, bamlanivimab and etesevimab, 2100 mg	Effective 2/9/2021 Drug code not reimbursed regardless of modifier
M0245	Intravenous infusion, bamlanivimab and etesevimab, includes infusion and post administration monitoring	Effective 2/9/2021

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

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.

- For specimen collection report one of the following codes*:
  - **99001** for specimen collection; **or**
  - **G2023** specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source
- 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)
- 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 Massachusetts state of 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 Massachusetts state of 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 Massachusetts state of 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
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system	Blue Cross will allow the use of these modifiers on **any** code during the COVID-19 Massachusetts state of emergency
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 1/1/2021 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 1/1/2021 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 Massachusetts state of emergency to specify that the office/outpatient E/M (99201-99215) 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) and POS 11 (office). Blue Cross will treat POS 02 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)

Telehealth and telephonic services

Effective for dates of service on or after March 16, 2020, Blue Cross will reimburse **all** covered services (COVID-19 **and** non-COVID 19 related) that are provided via telehealth or telephone.

Professional providers
Follow the same telehealth billing guidelines, including the use of the following modifiers on all lines billed:

- Practitioners must use modifier GT, 95, G0, or GQ to differentiate a telehealth (telemedicine) encounter from an in-person encounter with the patient.
- Any telehealth service must be reported with modifier GT, 95, G0, or GQ and the applicable place of service code as noted above. Blue Cross will allow the use of these modifiers on **any** code during the COVID-19 Massachusetts state of emergency.
- Telephonic codes (98966-98968, 99441-99443) **do not** require the use of any telehealth modifier.

Ancillary and behavioral health providers
(This section applies only to certain specialties. Click here to find out if your specialty is included.)

- When you provide any telephonic services, do not bill the specific telephonic CPT codes. Bill all covered services that you render either by telehealth or telephone as if you are performing a face-to-face service using the codes that are currently on your fee schedule.
- You must use one of the following telehealth modifiers (GT, 95, G0, and GQ) and the applicable place of service code as noted above. This will enable us to pay you the same rate we pay you for in-person, face-to-face visits.
- Blue Cross will allow the use of these modifiers for **any** service on your fee schedule during the COVID-19 Massachusetts state of emergency.

Acute care hospitals
When you provide telehealth or telephonic services:

- Bill on a facility claim using a professional revenue code with the telehealth or telephonic services outlined below.
- Bill for all other covered services rendered either by telehealth or telephone as if you are performing a face-to-face service, using the revenue and HCPCS/CPT code combinations that you would normally bill on a facility claim.
- Use one of the following telehealth modifiers on all lines billed: GT, 95, G0, or GQ.
- Telephonic codes (98966-98968, 99441-99443) **do not** require the use of any telehealth modifier.
- Medicare Advantage facilities follow CMS guidelines for telehealth services.

Telehealth and Telephonic Modifiers, CPT and HCPCS Codes
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.

Code	Service description	Comments
Modifiers		
GT	Via interactive audio and video telecommunication systems	**Blue Cross will allow the use of these modifiers on any covered code during the COVID-19 Massachusetts state of emergency.**
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	
CPT and HCPCS codes		
90791	Psychiatric diagnostic evaluation	Only applicable to behavioral health providers
90792	Psychiatric diagnostic evaluation with medical services	
90832	Psychotherapy, 30 minutes with patient and/or family member	
90833	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service	
90834	Psychotherapy, 45 minutes with patient and/or family member	
90836	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service	
90837	Psychotherapy, 60 minutes with patient and/or family member, consistent with the face-to-face visit	
90838	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure)	
90846	Family psychotherapy (without the patient present), 50 minutes	
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	
98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	Effective March 16, 2020, temporarily accepted until further notice Telehealth modifier not required Effective April 1, 2021, will be subject to Frequency Payment Policy edits
98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	Effective March 16, 2020, temporarily accepted until further notice Telehealth modifier not required Effective April 1, 2021, will be subject to Frequency Payment Policy edits
98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	Effective March 16, 2020, temporarily accepted until further notice Telehealth modifier not required Effective April 1, 2021, will be subject to Frequency Payment Policy edits

Code	Service description	Comments
98970	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	Effective March 16, 2020, temporarily accepted for FEP and Medicare Advantage products until further notice
98971	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	
98972	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.	Effective March 16, 2020, temporarily accepted until further notice
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.	Effective March 16, 2020, temporarily accepted until further notice
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.	Effective March 16, 2020, temporarily accepted until further notice
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.	Effective March 16, 2020, temporarily accepted until further notice
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.	
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.	
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.	
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.	Effective March 16, 2020, temporarily accepted until further notice
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.	Effective March 16, 2020, temporarily accepted until further notice
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	Effective March 16, 2020, temporarily accepted for FEP and

Code	Service description	Comments
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	Medicare Advantage products until further notice
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	Effective March 16, 2020, temporarily accepted until further notice Telehealth modifier not required Effective April 1, 2021, will be subject to Frequency Payment Policy edits
99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	Effective March 16, 2020, temporarily accepted until further notice Telehealth modifier not required Effective April 1, 2021, will be subject to Frequency Payment Policy edits
99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	Effective March 16, 2020, temporarily accepted until further notice Telehealth modifier not required Effective April 1, 2021, will be subject to Frequency Payment Policy edits
99495	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge	Effective March 16, 2020, temporarily accepted until further notice
99496	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of high complexity during the service period Face-to-face visit, within 7 calendar days of discharge	Effective March 16, 2020, temporarily accepted until further notice
G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth	Effective March 16, 2020, temporarily accepted for FEP and Medicare Advantage products until further notice
G0407	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth	
G0408	Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth	
G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth	Effective March 16, 2020, temporarily accepted for FEP and Medicare Advantage products until further notice
G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth	

Code	Service description	Comments
G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth	
G0459	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy	Effective March 16, 2020, temporarily accepted until further notice
G0508	Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth	Effective March 16, 2020, temporarily accepted for Medicare Advantage products until further notice
G0509	Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth	
G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment	Effective March 16, 2020, temporarily accepted for FEP and Medicare Advantage products until further notice
G2012	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	Effective March 16, 2020, temporarily accepted until further notice Effective April 1, 2021, will be subject to Frequency Payment Policy edits
G2250	Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment	Effective January 1, 2021, temporarily accepted for FEP and Medicare Advantage products until further notice Effective April 1, 2021, will be subject to Frequency Payment Policy edits
G2251	Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion	Effective January 1, 2021 Effective April 1, 2021, will be subject to Frequency Payment Policy edits
G2252	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	Effective January 1, 2021 Effective April 1, 2021, will be subject to Frequency Payment Policy edits

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 Massachusetts state of 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 Massachusetts state of 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 Massachusetts state of 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) - Behavioral 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 clinic setting
03/05/2021	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
04/29/2021	Removal of pharmaceutical treatment codes Q0239 and M0239 in response to FDA revoking the Emergency Use Authorization (EUA) for bamlanivimab when administered alone

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.