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Updated COVID-19 Billing Guidelines for Hospitals & Physicians

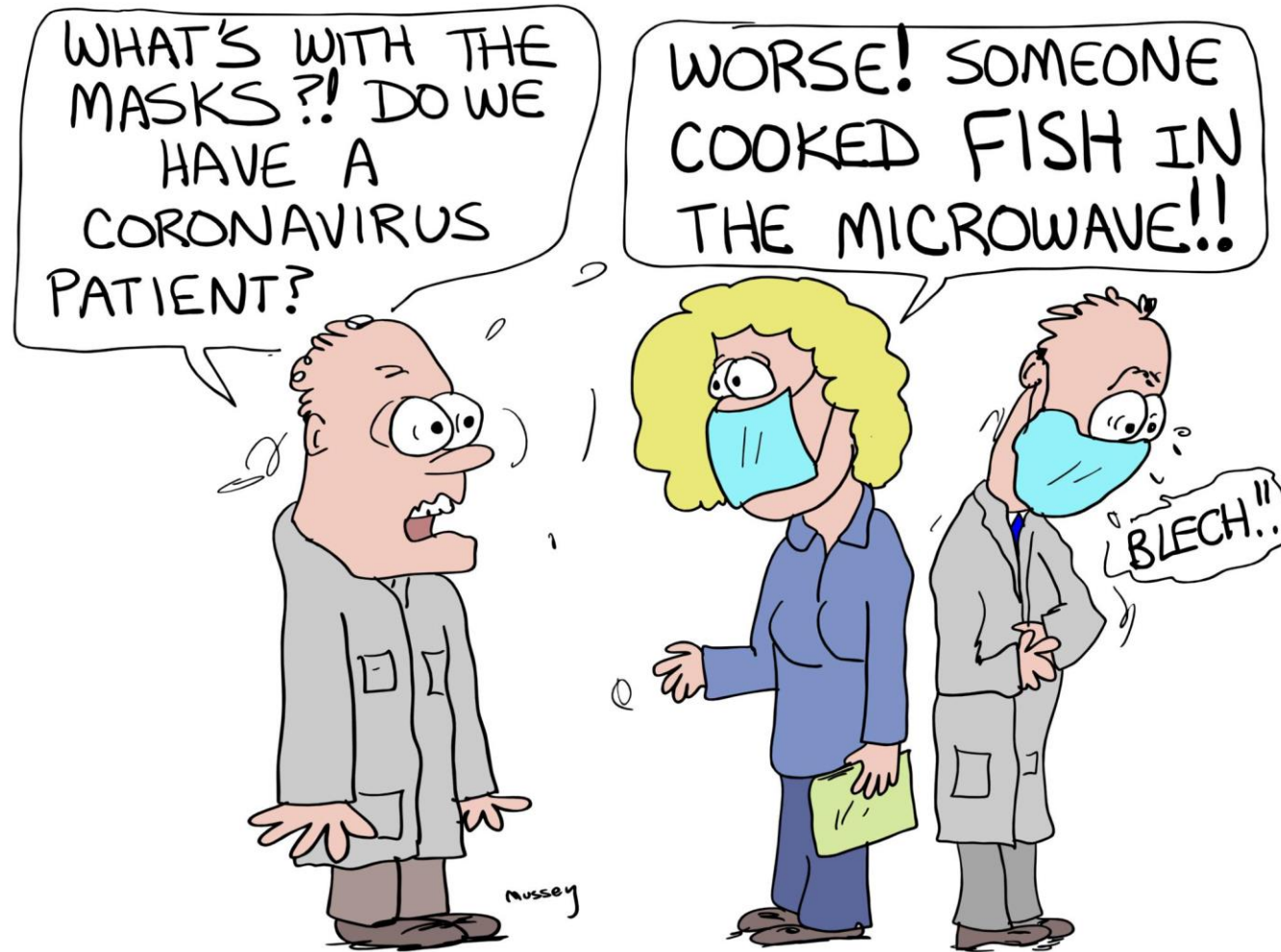
A Vitalware Webinar

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Outpatient Hospital Reporting & Reimbursement



Billing for Specimen Collection

- **Scenario #1 – Specimen is collected during the course of an E/M visit**
 - G2023 – Specimen collection for COVID-19, any specimen source
 - G2024 – Specimen collection for COVID-19 from an individual in a SNF or by a laboratory on behalf on a HHA, any specimen source
- ✓ **Both of these codes have been assigned status indicator of ‘N’ under the OPPS**
- ✓ **Both codes have an effective date of 3/1/20**

Billing for Specimen Collection

- **Scenario #2 – Specimen collection is only service performed**
 - Recommendation from the AMA is to assign low-level clinic visit code, such as 99211 or G0463
 - Question has been sent to CMS for recommendation
 - Vitalware will provide updates as we receive them



Codes for COVID-19 Infectious Agent Detection

Code	Description
U0001	CDC 2019 novel Coronavirus (2019-nCoV) real-time RT-PCR diagnostic panel
U0002	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC
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

Codes for COVID-19 Infectious Agent Detection

U0001	U0002	87635
<ul style="list-style-type: none"> ▪ Used for CDC labs ▪ Reimbursement rate of \$35.91 or \$35.92 based on MAC* ▪ Effective February 4, 2020 ▪ Accepted on or after April 1, 2020 	<ul style="list-style-type: none"> ▪ Used for all other methods in non-CDC labs ▪ Reimbursement of \$51.31 or \$51.33 based on MAC* ▪ Effective February 4, 2020 ▪ Accepted on or after April 1, 2020 	<ul style="list-style-type: none"> ▪ Used for nucleic acid tests using amplified probe technique ▪ Reimbursement rate of \$51.31 based on MAC* ▪ Effective March 13, 2020 ▪ Accepted on or after April 1, 2020

* Rate is subject to MAC approval pending a national rate determination by CMS

Codes for COVID-19 Infectious Agent Detection

Code	Description
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, <u>making use of high throughput technologies as described by CMS-2020-01-R</u>
U0004	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, <u>making use of high throughput technologies as described by CMS-2020-01-R</u>

Codes for COVID-19 Infectious Agent Detection

U0003	U0004
<ul style="list-style-type: none">▪ Used to identify tests that would otherwise be identified with 87635▪ Reimbursement rate of \$100▪ Effective April 14, 2020▪ Code is NOT retroactive	<ul style="list-style-type: none">▪ Used to identify tests that would otherwise be reported with U0002▪ Reimbursement rate of \$100▪ Effective April 14, 2020▪ Code is NOT retroactive

Codes for COVID-19 Antibody Detection

Code	Description
86328	Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single step method (eg, reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])
86769	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])

Codes for COVID-19 Antibody Detection

86328	86769
<ul style="list-style-type: none">▪ Used to identify testing performed using a strip that contains all components for antibody testing▪ Reported once per reagent strip assay▪ Reimbursement rate not yet published▪ Effective April 10, 2020	<ul style="list-style-type: none">▪ Used to identify testing performed using a multiple-step method▪ Reported once for each assay performed – Different immunoglobulin classes would be reported separately▪ Reimbursement rate not yet published▪ Effective April 10, 2020

Billing for Telehealth Services

- There is no facility fee for telehealth services at the current time
 - Facility fee is intended to compensate for supplies, equipment, and use of physical space
 - Recent expansions to telehealth services do not change the list of qualified providers who may perform telehealth services
 - CMS is actively working on modifying this policy due to feedback received from providers

Billing for Telehealth Services



- Scenario #1 – Physician located in hospital provides telehealth services to patient at home
 - No facility fee
- Scenario #2 – Physician located at home or other remote location provides telehealth services to patient in hospital
 - Assign Q3014, *Telehealth originating site facility fee*

IPPS Reimbursement for COVID-19 Cases

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**"I use so much alcohol-based hand sanitizer,
my hands had to join a 12-step program!"**

MS-DRG Grouping

Diagnosis Code	CC Status	MS-DRG	Unadjusted \$\$
U07.1, COVID-19	MCC	177 – Respiratory Infections and Inflammations with MCC	177 - \$11,400.30
		178 – Respiratory Infections and Inflammations with CC	178 - \$7,494.71
		179 – Respiratory Infections and Inflammations without CC/MCC	179 - \$5,220.92
		791 – Prematurity with Major Problems	791 - \$22,944.08
		793 – Full-Term Neonate with Major Problems	793 - \$23,567.98
		974 – HIV with Major Related Condition with MCC	974 - \$16,118.48
		975 – HIV with Major Related Condition with CC	975 - \$8,089.68
		976 – HIV with Major Related Condition without CC/MCC	976 - \$5,510.87

MS-DRG Adjustments for COVID-19 Cases



- Weighting factor for COVID-19 cases will be increased by 20% during the PHE
- Adjustment will be made automatically by the MACs
- Accounts will be identified by diagnosis code
 - B97.29 for discharges occurring between January 27 and March 31
 - U07.1 for discharges occurring April 1 through end of PHE

Hospital Quarantine Patients

- Medicare will pay for the entire stay, including quarantine time, for patients who remain quarantined in a hospital to avoid infecting other individuals and who may not meet the need for inpatient care
- Hospitals may not charge a differential for a private room that is required due to quarantined status
- Waiver of “3-day prior hospitalization rule” for coverage of a SNF stay

CMS Flexibilities – Hospital without Walls

- Hospitals able to provide patient care in temporary expansion sites not considered part of a healthcare facility
 - Locations must be approved by the State
- Patients can be screened for COVID-19 at an offsite location
- Any location meeting CoP within the hospital or provider-based department has flexibility to operate to meet hospital needs
- Acute care inpatients may be housed in excluded distinct part units
 - Psychiatric and Rehab inpatients can be cared for outside of distinct part units

CMS Flexibilities – Hospital without Walls

- Waiver of 25-bed limitation for critical access hospitals
- Waiver of 96-hour length of stay limitation for critical access hospitals
- Waiver of rural requirement for critical access hospitals to allow for patient surge
- Waiver of provisions related to telemedicine to allow for increased access to care for patients in the hospital

CMS Flexibilities – Patients Over Paperwork

- Verbal orders may be authenticated outside of 48-hour window
- Waiver of reporting requirements for patients who expire due to their disease and required soft wrist restraints
- Limited discharge planning required
 - Focus on ensuring that patients are discharged to an appropriate setting with necessary information and goals of care
- Flexibility in completion of medical records
- Waiver of advanced directives requirements

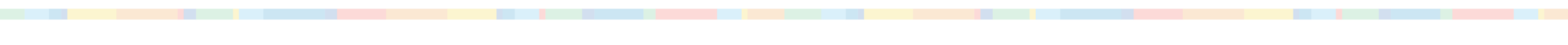
CMS Flexibilities – Patients Over Paperwork

- Extension for data submission deadline of occupational mix of employees to August 3, 2020
- Waiver of utilization review requirements
- Waiver of 2019 Q4, 2020 Q1, and 2020 Q2 quality reporting program data
- Waiver of individual patient nursing plan requirements/policies and procedures for departments requiring an RN

CMS Flexibilities – Patients Over Paperwork

- Waivers of requirements for surge sites
 - Current therapeutic diet manual not required
 - Emergency preparedness policies and procedures not required
- Extension for cost reporting data for the next fiscal year
 - For fiscal years ending 10/31 and 11/30, reports will be due June 30, 2020
 - For fiscal years ending 12/31, cost reports will be due July 31, 2020

CMS Flexibilities – Workforce

- Waiver of sterile compounding requirements to allow used face masks to be removed and retained
 - Physicians with expiring privileges may continue to practice without full medical staff review and approval
 - Patients may be under care of physician's assistant or nurse practitioner
 - CRNA supervision will be at the discretion of the hospital and state law
 - Personnel qualified to provide respiratory care do not need to be designated in writing
- 

Professional Reimbursement Considerations



Claims Submission

- Condition Code DR – Disaster Related
 - All items are disaster related
- Modifier CR – Catastrophe/Disaster Related
 - Individual line items that are related
- Modifier CS – Cost-sharing for specified COVID-19 testing-related services that result in an order for or administration of a COVID-19 test

Claims Submission

- Medical visit which prompts the ordering of the COVID-19 lab
- “For services furnished on March 18, 2020, and through the end of the PHE, outpatient providers, physicians, and other providers and suppliers that bill Medicare for Part B services under these payment systems should use the CS modifier on applicable claim lines to identify the service as subject to the cost-sharing waiver for COVID-19 testing-related services and should NOT charge Medicare patients any co-insurance and/or deductible amounts for those services.”
- CMS indicates more guidance to be issued

Claims Submission

- Medical service that prompts lab order for COVID-19 test
 - Office and other outpatient services
 - Hospital observation services
 - Emergency department services
 - Nursing facility services
 - Domiciliary, rest home, or custodial care services
 - Home services
 - Online digital evaluation and management services

CMS Flexibilities

- Stark Law Waivers
- Self-Referral to friends, family
- Fair market value rent for equipment or services
- Financial support – Physician-owned hospital can receive personal loan from owner(s)
- Physician-owned hospitals can increase number of beds, operating rooms, procedure rooms

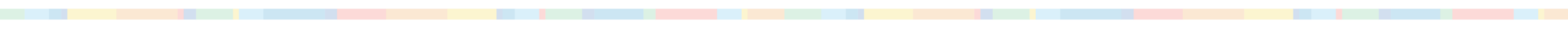
CMS Flexibilities

- Extra benefits such as meals, laundry, child care
- Group practice restrictions for services provided in patient's home. One physician can order items or services for another's patient
- Radiological or laboratory services in parking lots rented part-time
- Provision of items & services related to COVID-19 can exceed non-monetary compensation cap

CMS Flexibilities

- Signature Requirements
- Merit-Based Incentive Program data submission deadline extended 30 days
- Waived face-to-face and specific practitioner type requirements for most National & Local Coverage Determinations
- Accelerated and Advance Payment Program
- Provider enrollment hotlines

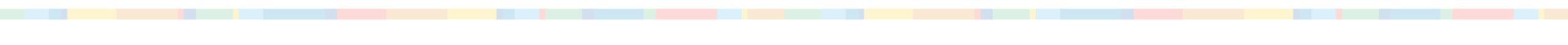
CMS Flexibilities

- Can provide services from home without updating 855P or PECOS information
 - Can contract with auxiliary personnel to provide incident to services & bill
 - Hospital admissions may be done by advanced registered nurse practitioners (ARNPs)
 - Waive requirement that physician or nonphysician (NPP) must be licensed in state where practicing
- 

CMS Flexibilities

- Frequency limits for monthly “hands on” visit can be telehealth
 - ESRD
 - Hospice
 - Inpatient Rehabilitation Facility (IRF)
- Direct Supervision can be virtual – audio/video presence

CMS Flexibilities

- Teaching Physician Supervision may be virtual, with exceptions
 - Residents may moonlight in the inpatient setting
 - Teaching physician may review and sign off on service – no physical presence
 - Homebound definition broadened
 - Does not need to be an established patient
- 

CMS Flexibilities

- Telehealth updates to codes
- Provider updates for services
- Physical therapy services added – but not therapists
- Evaluation and Management (E/M) code selection based on time or medical decision making (MDM), not history & exam
- Audio/video may take the place of face-to-face requirement

Online Services or E-Visits

99421 – 99423

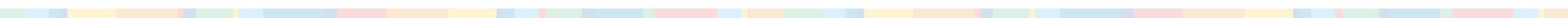
Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days

Flexibility – does not have to be an established patient

98970–98972

G2061 – G2063

Qualified nonphysician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days



Online Services or Virtual Check-in

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

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

Telephone Services

99441 – 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

98966 – 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

Telehealth Services

- Is the service telehealth?
- Use place of service that would occur without the PHE
- Place of Service
 - 02 *Telehealth (traditional telehealth)*
 - 11 Office
 - 31 *Skilled Nursing Facility*
 - 32 *Nursing Facility*

Telehealth Services

- Modifiers
 - *95 Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System*
 - *GT Via interactive audio and video telecommunication systems*
 - *G0 Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke*
- *Do not need to report disaster related modifier CR*

Telehealth Providers

May provide evaluation and management (E/M) services

Physicians

Nurse practitioners (NPs)

Physician assistants (PAs)

Nurse midwives

May not provide E/M services – other limits

Certified nurse anesthetists

Clinical psychologists (CP)

Clinical social workers (CSW)

Registered dietitians (RD)

Nutrition professionals

Physical therapist (PT)

Occupational therapist (OT)

Speech language pathologist (SP)

PT/OT/SP Caution

- PT/OT/SP not an approved distant site practitioner
- Approved for some telephone services
- Professional services means submitted on CMS-1500 (855P)
- CMS hinting at changes, but no guidance yet

Telehealth

- Must use audio/visual to be telehealth
- Audio only is telephone services, not telehealth
- Older patients without audio/visual or poor/no internet? Telephone only
- Physician and patient in same facility, but not face-to-face
 - Yes, but do not bill as a telehealth service

Telehealth

- CMS-1500 claim needs
 - CPT/HCPCS codes for service
 - Place of service
 - Modifier(s)
 - Provider's place of service
- Patient and provider NOT in the same place

Expanded Services

- Emergency Department Visits, Levels 1-5
- Domiciliary, Rest Home, Custodial Care, New or Established
- Home Visits, New or Established
- Care Planning for patients with cognitive impairment
- Psychological and neuropsychological testing
- Therapy Services, physical and occupational

Evaluation and Management

- E/M code selection may be based on medical decision making (MDM) or time
- Time is all time on the date of the encounter
- Do not need to use history or exam
- Use time from the Calendar Year (CY) 2020 Medicare Physician Final Rule or current code descriptor
- No change to definition of MDM

E/M Median Time

CPT Code	Median Time
99201	10 minutes
99202	15 minutes
99203	20 minutes
99204	30 minutes
99205	45 minutes

E/M Median Time

CPT Code	Median Time
99211	5 minutes
99212	10 minutes
99213	15 minutes
99214	25 minutes
99215	35 minutes

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- **Hospitals: CMS Flexibilities to Fight COVID-19**
<https://www.cms.gov/files/document/covid-hospitals.pdf>
- **New Waivers for Inpatient Prospective Payment System (IPPS) Hospitals, Long-Term Care Hospitals (LTCHs), and Inpatient Rehabilitation Facilities (IRFs) due to Provisions of the CARES Act**
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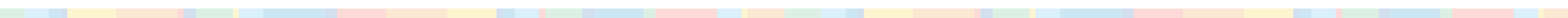
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