Updated COVID-19 Billing Guidelines for Hospitals & Physicians

April 23, 2020
Webinar FAQ Document

1. **Question** – What codes, other than the E/M code, require the CS modifier?

   Answer – Modifier CS, *Cost-sharing for specified COVID-19 testing-related services that result in an order for or administration of a COVID-19 test,* was updated for use in identifying medical visits and other diagnostic tests which result in the need for 2019 Novel Coronavirus (COVID-19) testing. Therefore, it would be appropriate to assign modifier CS to codes that describe COVID-19 testing, including 86328, 86769, 87635, G2023, G2024, U0001, U0002, U0003, and U0004.

   Additionally, the Families First Coronavirus Response Act states that cost sharing is waived for "items and services furnished to an individual…that result in an order for or administration of…."[1] This verbiage is causing some confusion regarding which specific items and services should be provided without cost sharing. CMS is stating that additional guidance is forthcoming, but has not published at the current time.

2. **Question** – Can you please explain the appropriate use for HCPCS code Q3014?

   Answer –Healthcare Common Procedure Coding System (HCPCS) code Q3014, *Telehealth originating site facility fee,* is used by the facility only when the patient is physically located in the facility and a physician or other qualified healthcare provider is using audio/video equipment to provide telehealth services for the patient.[2]

3. **Question** – What is the effective date for the waiver on the 3-day rule for SNF admission?

   Answer – The 1812(f) waiver and 1135 blanket waivers are retroactively effective to March 1, 2020.[3]

4. **Question** – Do the blanket waivers apply to all patients or just for patients with COVID-19?

   Answer – The 1135 and 1812(f) blanket waivers have been issued to assist in fighting the spread of COVID-19. As such, the blanket waivers may apply to any patient, and not only those diagnosed with COVID-19. There are various nuances within the waivers to assist in determining if particular items may or may not apply. For example, the *Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency* interim final rule with comment period expands the definition of homebound,

[1] "Families First Coronavirus Response Act", available at https://www.congress.gov/bill/116th-congress/house-bill/6201/text, page 134, Stat 201 (March 18, 2020)
[2] Transmittal R2095OTN, "Revisions to the Telehealth Billing Requirements for Distant Site Services", available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2095OTN.pdf (June 20, 2018)
[3] "COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers", available at: https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf, page 9 (April 21, 2020)

but also states that a person who is self-quarantined does not meet this definition.[4] Documentation should be available in each patient's record for whom care was provided under one of these waivers.

5. **Question** – Should modifier CR and modifier CS both be assigned for facility charges?

   Answer – Both modifiers may be assigned for outpatient facility charges when reporting conditions are met for each modifier.[5] Modifier CR, *Catastrophe/Disaster Related,* is mandatory for institutional providers in billing situations related to COVID-19 to identify line item services that are related to a formal waiver.[6] Modifier CS, *Cost-sharing for specified COVID-19 testing-related services that result in an order for or administration of a COVID-19 test,* is used to identify line items for which cost-sharing should be waived under the Families First Coronavirus Response Act.

6. **Question** – Should hospitals assign condition code DR for patients who have not been diagnosed with COVID-19 due to the possibility of meeting one of the waivers?

   Answer – Use of condition code DR, *Disaster Related,* is not based upon the diagnosis of the patient. Rather, the condition code is used when all items and services submitted on a claim are related to a COVID-19 waiver. If the patient's visit is impacted by COVID-19, then the condition code is appropriate. Examples provided by CMS are instances where a patient is housed in a separate unit to keep the patient from the COVID-19 positive population. Medical record documentation that explains how the patient's care was impacted by COVID-19 should be available.[7]

7. **Question** – Should we report modifier CS for commercial payers as well?

   Answer – Yes; modifier CS, *Cost-sharing for specified COVID-19 testing-related services that result in an order for or administration of a COVID-19 test,* should be appended for all payers. The Families First Coronavirus Response Act states that the cost-sharing waiver for COVID-19 testing applies to group health plans and to individual health plans, as well as Medicare, Medicaid, Tricare, and contracted Indian Health Services.[8] Additionally, most private insurance payers have followed suit in waiving cost sharing for COVID-19 services, although it may be necessary to check with each payer regarding their specific policies related to COVID-19 cost sharing.

8. **Question** – Our physicians do their own coding for our private practice. We do our best to check the submitted charges, codes, and modifiers, but sometimes we don't catch an incorrect code or modifier until

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[4] "Medicare and Medicaid Program; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency", page 63, available at https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-06990.pdf (April 6, 2020)

[5] Pub. 100-04 Medicare Claims Processing Manual, "Chapter 38 Emergency Preparedness Fee-for-Service Guidance, Section 10 Use of the CR Modifier and DR Condition Code for Disaster/Emergency-Related Claims", page 2, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c38.pdf (July 25, 2014)

[6] "COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing", pages 35-35, available at https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf (April 23, 2020)

[7] "COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing", page 10, available at https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf (April 23, 2020)

[8] "Families First Coronavirus Response Act", available at https://www.congress.gov/bill/116th-congress/house-bill/6201/text, page 134, Stat 201 (March 18, 2020)

the remittance advice comes back from the payer. Do you have any recommendations on the best way to ensure that modifier CS is applied to all necessary visits?

Answer – Physician education on the use of the modifiers would be Vitalware Best Practice. If that is not feasible at this time, consider reviewing accounts that result in additional services, particularly laboratory tests, for review. You may also wish to review accounts that contain diagnosis codes for COVID-19, such as U07.1, *COVID-19,* or that contain diagnosis codes for signs/symptoms frequently associated with possible COVID-19 infections, such as Z20.828, *Contact with and (suspected) exposure to other viral communicable diseases,* Z03.818, *Encounter for observation for suspected exposure to other biological agents ruled out,* Z11.59, *Encounter for screening for other viral diseases,* R05, *Cough,* R06.02, *Shortness of breath,* or R50.9, *Fever, unspecified.*

9. **Question** – At our facility, many COVID-19 patients receive very expensive medications. Is there any additional reimbursement for these drugs other than a potential outlier adjustment?

   Answer – While there is no additional reimbursement available for medications used to treat COVID-19 infections, there is a 20 percent increase in the weighting factor of the assigned Diagnosis-Related Group (DRG) for individuals diagnosed with COVID-19 who are discharged during the COVID-19 Public Health Emergency period. Accounts that qualify for the 20 percent increase will be identified and automatically adjusted by the Medicare Administrative Contractors (MACs) based upon diagnosis codes assigned to the accounts. Accounts that have diagnosis code B97.29, *Other coronavirus as the cause of diseases classified elsewhere,* assigned will be automatically adjusted for discharges occurring on or after January 27, 2020 and on or before March 31, 2020. The assignment of diagnosis code U07.1, *COVID-19,* will trigger an automatic increase in the DRG weighting factor for discharges occurring on or after April 1, 2020 through the end of the public health emergency.[9] Additionally, Medicare will base outlier reimbursement on the entire cost of the stay for Medicare beneficiaries with COVID-19, even if the patient no longer meets criteria for acute inpatient care but needs to remain isolated in order to avoid infecting other individuals.[10]

10. **Question** – How do you recommend billing for oral drugs given for treatment of COVID-19 that may be very expensive. Can you recommend different revenue codes or HCPCS codes other than 0637 and A9270 that will cause the patients to be responsible for these charges?

    Answer – The COVID-19 Public Health Emergency should not require any changes in your facility's handling of drugs that are considered to be usually self-administered. For inpatient accounts, the revenue code 025x - *Pharmacy* should be used, and the drugs would be included in the DRG payment. For outpatient accounts, you should follow your facility's established policy and procedure for self-administered drugs.

11. **Question** – Can teaching physicians conduct supervision via audio only, or do they have to use audio and video?

[9] MLN Matters Number SE20015, "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", available at https://www.cms.gov/files/document/se20015.pdf (April 15, 2020)

[10] "COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing", page 9, available at https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf (April 23, 2020)

Answer – Teaching physicians can provide supervision virtually through audio/video real-time communications technology. Note that this does not apply in the case of surgical, high-risk, interventional, or other complex procedures, services performed through an endoscope, or anesthesia services. When the term "audio/video real-time communications technology" is used, this does not include audio-only communication.[11]

12. **Question** – Is it true that only the outpatient visit codes in the range of 99201 through 99215 can be coded based upon time or medical decision making?

    Answer – Yes. At this time, CMS has stated that outpatient office evaluation and management (E/M) level selection for visits provided through telehealth may be based on medical decision making or time. Time is defined as all time associated with the E/M on the day of the encounter, and the requirement regarding documentation of a history and/or physical exam has been removed.[12]

13. **Question** - Can you please explain the difference between a virtual check-in and an E-visit?

    Answer – A virtual check-in is a short, patient-initiated communication through audio or visual means of communication that Medicare has defined as a brief communication service with a practitioner via a number of communication technology modalities including synchronous discussion over a telephone or exchange of information through video or image. Medicare expects that these virtual services will be initiated by the patient, but the providers may need to educate patients on the availability of these services. E-visits are non-face-to-face patient-initiated communications with a practitioner through the use of an online patient portal.[13]

14. **Question** – Can you expand on the use of modifier CR? Should it be hard-coded in the CDM for the new telephone services 99441-99443 and 98966-98968?

    Answer – Modifier CR, *Catastrophe/Disaster Related,* is to be reported on outpatient institutional claims (CMS-1450, UB-04) or non-institutional claims (CMS-1500) and is mandatory for applicable HCPCS codes where payment is based upon a formal waiver, such as the blanket waivers now in effect for the COVID-19 Public Health Emergency.[14] You may choose to hard code the modifier in your charge description master (CDM), but will need to update the line items when the public health emergency has officially ended. Medicare has stated that they will not deny claims due to the presence of this modifier for items or services

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[11] "Teaching Hospitals, Teaching Physicians and Medical Residents: CMS Flexibilities to Fight COVID-19", page 1, available at https://www.cms.gov/files/document/covid-teaching-hospitals.pdf (March 29, 2020)

[12] "Medicare and Medicaid Program; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency", pages 141-142, available at https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-06990.pdf (April 6, 2020)

[13] CMS Press Release, "Medicare Telemedicine Health Care Provider Fact Sheet", available at https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet (March 17, 2020)

[14] Pub. 100-04 Medicare Claims Processing Manual, "Chapter 38 Emergency Preparedness Fee-for-Service Guidance, Section 10 Use of the CR Modifier and DR Condition Code for Disaster/Emergency-Related Claims", page 3, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c38.pdf (July 25, 2014)

not related to a COVID-19 waiver, but you may wish to check with other payers before adding this modifier to your CDM.

15. **Question** – If the provider is coding based on the total time spent with the patient, should they note the amount of time spent within the progress notes?

    Answer – The guidance provided states that documentation of the E/M is to ensure quality and continuity of care.[15] Although there is no explicit instruction regarding documentation requirements for the amount of time spent within the current guidance, if time spent is the basis for code selection, there should be some way to verify the amount of time spent in case of an audit. The progress notes are a logical place to document this information, but it's not required that this information be documented specifically within the progress notes.

16. **Question** – Do critical access hospitals always use the GT modifier for telehealth services?

    Answer – Modifier GT, *Via interactive audio and video telecommunication systems,* is required for telehealth services billed under Critical Access Hospital (CAH) Method II on institutional claims. The current public health emergency has not changed the use of modifier GT.[16]

17. **Question** – Can you provide guidance on billing the convalescent plasma? Specifically, is 36430 the correct code to bill for administration?

    Answer – COVID-19 convalescent plasma has not yet been approved for use by the U.S. Food & Drug Administration (FDA). Due to this, your facility will need to be enrolled in a clinical trial and follow the clinical trial claims submission process.[17] According to uscovidplasma.org, the plasma may be transfused either centrally or peripherally.[18] Code selection is based upon whether the patient is inpatient or outpatient, and whether the transfusion is central or peripheral. For outpatient accounts, CPT® code 36430, *Transfusion, blood or blood components,* would be appropriate. Inpatient accounts would use ICD-10-PCS codes within the 302xxxx range.

18. **Question** – How do I bill a new admission to a SNF that was done by telehealth to Medicare?

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[15] "Medicare and Medicaid Program; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency", page 141, available at https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-06990.pdf (April 6, 2020)

[16] Transmittal R2095OTN, "Revisions to the Telehealth Billing Requirements for Distant Site Services", available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2095OTN.pdf (June 20, 2018)

[17] "Recommendations for Investigational COVID-19 Convalescent Plasma", available at https://www.fda.gov/vaccines-blood-biologics/investigational-new-drug-ind-or-device-exemption-ide-process-cber/recommendations-investigational-covid-19-convalescent-plasma#Pathways%20for (April 13, 2020)

[18] "Clinical Investigator's Brochure for Use of Convalescent Plasma to Treat Coronavirus-19 (COVID-19) Disease", available at https://www.uscovidplasma.org/ (April 23, 2020)

Answer – You are able to bill the code that would have been used if there were no COVID-19 Public Health Emergency, such as CPT® codes 99304-99306 for the initial nursing facility care.[19] As part of the flexibilities instituted by CMS for fighting COVID-19, CMS is waiving the requirement in 42 CFR 483.30 for physicians and non-physician practitioners to perform in-person visits for nursing home residents and will allow for visits to be conducted via telehealth, as appropriate.[20]

19. **Question** – If a patient receives the COVID-19 antigen plasma, do we need to add a modifier?

    Answer – For outpatient accounts, modifier Q0, *Investigational clinical service provided in a clinical research study that is in an approved clinical research study,* or modifier Q1, *Routine clinical service provided in a clinical research study that is in an approved clinical research study,* may be necessary since the use of convalescent plasma has not yet been approved for use by the FDA. This requires that facilities providing this service be enrolled in a clinical trial and follow the clinical trial claims submission process. For inpatient and outpatient accounts, condition code 30, *Qualifying Clinical Trial,* should also be used. Value code D4, *Clinical Trial Number Assigned by NLM/NIH,* should be reported, and must contain the 8-digit National Clinical Trial (NCT) number. Additionally, ICD-10-CM code Z00.6, *Encounter for examination for normal comparison and control in clinical research program,* should be reported.[21] Finally, modifier CR, *Catastrophe/Disaster Related,* should be appended to outpatient cases.[22]

20. **Question** - Do we apply modifier CR and modifier CS to CPT® code 87635 and HCPCS code U0003?

    Answer – Modifier CR, *Catastrophe/Disaster Related,* should be appended to CPT® code 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,* and HCPCS code 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,* since both of these services are related to the COVID-19 public health emergency.[23] Modifier CS, *Cost-sharing for specified COVID-19 testing-related services that result in an order for or administration of a COVID-19 test*, should be appended to items and services that have a cost-sharing amount, to indicate that the cost sharing portion should be waived. If the payer will adjudicate the claim without applying a cost-sharing amount to the patient, then the modifier is not necessary. CMS has stated that laboratory services generally have no cost-sharing amount, so the modifier may not be necessary.

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[19] COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing, page 21, available at https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf (April 23, 2020)

[20] "Long Term Care Facilities (Skilled Nursing Facilities and/or Nursing Facilities): CMS Flexibilities to Fight COVID-19", page 4, available at https://www.cms.gov/files/document/covid-long-term-care-facilities.pdf (March 28, 2020)

[21] Pub. 100-04 Medicare Claims Processing Manual, "Chapter 32 Billing Requirements for Special Services, Section 69 Qualifying Clinical Trials", pages 81-85, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c32.pdf (March 4, 2005)

[22] Pub. 100-04 Medicare Claims Processing Manual, "Chapter 38 Emergency Preparedness Fee-for-Service Guidance, Section 10 Use of the CR Modifier and DR Condition Code for Disaster/Emergency-Related Claims", page 3, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c38.pdf (July 25, 2014)

[23] Pub. 100-04 Medicare Claims Processing Manual, "Chapter 38 Emergency Preparedness Fee-for-Service Guidance, Section 10 Use of the CR Modifier and DR Condition Code for Disaster/Emergency-Related Claims", page 3, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c38.pdf (July 25, 2014)

However, if the patient's deductible has not have been met yet, appending the modifier will ensure the service isn't applied to the patient's deductible.[24]

21. **Question** – Our facility has licensed social workers and registered dieticians who normally bill facility services on the UB-04. Are we able to charge and bill anything for these professionals when they provide telephone or telehealth services?

    Answer – No. At this time, only professional services submitted on the CMS-1500 may be used to report telephone or telehealth services.[25] If a beneficiary is in a healthcare facility and receives a service via telehealth, the healthcare facility would only be eligible to bill for the originating site facility fee using HCPCS code Q3014, *Telehealth originating site facility fee.* CMS has been hinting that this may change, but no update has been released yet.[26]

22. **Question** – What place of service should be used for HCPCS code Q3014 when the patient is admitted and the physician is providing telehealth services from his/her home?

    Answer – HCPCS code Q3014, *Telehealth originating site facility fee*, is reported on a facility claim, and there is no field locator for place of service on the facility claim (CMS-1450).[27]

    The physician providing telehealth services would assign the place of service code on the professional claim that would have been assigned in the absence of the current public health emergency, such as 21, *Inpatient Hospital*.[28]

23. **Question** – Can you explain the difference between modifier CR and modifier 95?

    Answer – Modifier 95, *Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System,* should be applied to line items billed on non-institutional claims that describe services furnished via telehealth with dates of service on or after March 1, 2020 and for the duration of the public health emergency. Modifier CR, *Catastrophe/disaster related,* is used by both institutional and

[24] "Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)", page 3, available at https://www.cms.gov/files/document/se20011.pdf (April 10, 2020)
[25] "Medicare Telehealth Frequently Asked Questions, Question #13, available at https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf (March 17, 2020)
[26] CMS Outreach & Education Open Door Forums, "Podcasts and Transcripts, April 16, 2020 Office Hours", page 13, available at https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts (April 16, 2020)
[27] Pub. 100-04 Medicare Claims Processing Manual, "Chapter 25 Completing and Processing the Form CMS-1450 Data Set", pages 2-10, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c25.pdf (April 3, 2014)
[28] COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing, "Medicare Telehealth, Question #5", page 21, available at https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf (April 23, 2020)

non-institutional providers to identify Part B line items that are provided based upon a formal waiver.[29] It should be noted that CMS is not requiring modifier CR on telehealth services.[30]

24. **Question** – Is Medicare waiving the MSPQ required questions and answers in light of virtual visits and telehealth services, or should offices try and take steps to ensure that the MSPQ questions get answered for these services?

    Answer – It does not appear that this question has been addressed by CMS. However, this question was raised during the Open Door Forum CMS Office Hours audioconference on April 23, 2020. The guidance provided from CMS stated they would have to check and would provide information at a later date. It sounds like the issue is under consideration, but there has been no formal waiver of the requirement as yet.[31]

25. **Question** – Is it your understanding that condition code DR would apply to inpatient claims and that modifier CS would apply to outpatient claims? Would condition code DR and modifier CS both need to be applied to the same claim?

    Answer – Condition code DR, *Disaster Related,* and modifier CS, *Cost-sharing for specified COVID-19 testing-related services that result in an order for or administration of a COVID-19 test,* are used for different purposes and therefore may both need to be applied to the same claim based upon the circumstances surrounding each individual account and care setting. Condition code DR would be assigned by institutional providers at the claim level when all of the items and services billed on the claim are related to a COVID-19 waiver on both inpatient and outpatient claims.[32] Modifier CS is used to identify line items on both institutional and non-institutional claims for which cost-sharing should be waived under the Families First Coronavirus Response Act.

26. **Question** – We believe that physical therapists, occupational therapists and speech-language pathologists are in the best position to provide telehealth services to patients requiring therapy to minimize risk, keep patients up and mobile, and limit the use of personal protective equipment. Do you believe CMS will allow therapists to provide telehealth services during the pandemic?

    Answer – CMS has hinted broadly that therapists will be allowed to provide telehealth services during this public health emergency. Unfortunately, no formal announcement has been made at the current time. We believe CMS will allow these providers to perform telehealth services, but we do not currently have details on

[29] Pub. 100-04 Medicare Claims Processing Manual, "Chapter 38 Emergency Preparedness Fee-for-Service Guidance, Section 10 Use of the CR Modifier and DR Condition Code for Disaster/Emergency-Related Claims", page 3, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c38.pdf (July 25, 2014)
[30] MLN Matters Number SE20011, "Medicare Fee-for-Service (FFS) Response to the Public health Emergency on the Coronavirus (COVID-19), page 2, available at https://www.cms.gov/files/document/se20011.pdf (April 10, 2020)
[31] CMS Outreach & Education Open Door Forums, "Podcasts and Transcripts, April 16, 2020 Office Hours", page 13, available at https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts (April 16, 2020)
[32] Pub. 100-04 Medicare Claims Processing Manual, "Chapter 38 Emergency Preparedness Fee-for-Service Guidance, Section 10 Use of the CR Modifier and DR Condition Code for Disaster/Emergency-Related Claims", page 3, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c38.pdf (July 25, 2014)

this.[33] At the current time, CMS has not changed the list of distant site practitioners who are eligible to perform telehealth services, and this list does not currently include physical therapists, occupational therapists, or speech-language pathologists.[34]

27. **Question** – Do the new time documentation guidelines only apply for Medicare patients and for other payers who specifically state they are following the Medicare guidelines?

    Answer – The new time guidelines apply to Medicare and Medicaid. Adoption by other payers will be a payer-specific decision.[35] We recommend that you check with other payers to determine if they are adopting the new time guidelines during the public health emergency.

28. **Question** – Medicaid has stated they will not cover 99441-99443 for telephone visits but will accept the new and established E/M codes in their place as they are waiving the video requirement during the pandemic. Is it appropriate to map CPT® code 99441 to 99211, 99442 to 99212 and 99443 to 99213?

    Answer – It is not possible to directly map codes for telephone visit services to new and established E/M codes. Codes should be selected based upon the documentation in the medical record and in accordance with the specific payer guidance. Additionally, it appears that at least certain state Medicaid programs are allowing the use of CPT®codes 99441-99443 to report telephone services. Therefore, we would recommend checking with your particular payers regarding appropriate reporting of these services to ensure accurate coding and reimbursement.

[33] CMS Outreach & Education Open Door Forums, "Podcasts and Transcripts, April 16, 2020 Office Hours", page 13, available at https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts (April 16, 2020)

[34] CMS-1744-IFC, "Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency", pages 36-41, available at https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-06990.pdf (April 6, 2020)

[35] "Medicare and Medicaid Program; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency", pages 141-142, available at https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-06990.pdf (April 6, 2020)