Updated COVID-19 Billing & Coding: Recent Updates and Review of Changes

October 8, 2020
Webinar FAQ Document

1. **Question** – Please clarify that the CS modifier is NOT required on pre-admission testing but that we would need to append the CR modifier?

   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,* would not be required on pre-admission testing. Modifier CR, *Catastrophe/Disaster Related*, should be used to identify Part B line item services/items that are related to a COVID-19 waiver.[1]

2. **Question** – We have had multiple questions come up regarding modifier CS. For a lab using Place of Service 81, *A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office*, are we required to use modifier CS on all line items related to COVID-19 to have cost share waived?

   Answer – If your laboratory technicians are collecting the specimen and you are submitting a service such as Current Procedural Terminology (CPT®) code 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. Typically, 5 minutes are spent performing or supervising these services*, then you would need to append modifier CS, *Cost-sharing for specified COVID-19 testing-related services that result in an order for or administration of a COVID-19*. Language in the Families First Coronavirus Response Act (FCRA) stipulates the waiver of cost sharing is related to the medical visit. Modifier CS would not need to be appended to any laboratory tests.[2]

3. **Question** – Can you please clarify the use of modifier CS, in relation to labs or chest x-rays done for COVID-related reasons?

   Answer – Language in the FCRA stipulates the waiver of cost sharing is related to the medical visit related to evaluating the patient for the need to test. The FCRA lists the medical visits as office and other outpatient services, hospital observation services, emergency department services, nursing facility services, domiciliary, rest home or custodial care services, home services or online digital evaluation and management services.[3]

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[1] MLN Matters™ "Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)", pages 1-7, available at https://www.cms.gov/files/document/se20011.pdf (August 26, 2020)
[2] Public Law No: 116-127 "Families First Coronavirus Response Act", available at https://www.congress.gov/bill/116th-congress/house-bill/6201/text (March 18, 2020)
[3] Public Law No: 116-127 "Families First Coronavirus Response Act", available at https://www.congress.gov/bill/116th-congress/house-bill/6201/text (March 18, 2020)

The Centers for Medicare & Medicaid Services (CMS) has stated that because laboratory services are covered without a copayment or coinsurance amount, the modifier is not required. Because the chest x-ray is not a medical visit, it is not eligible for the application of the modifier.

4. **Question** – Is it true that CMS has indicated that the CS modifier is only to be used when a test is ordered for COVID-19 professional billing?

   Answer – That is partially correct. Application of modifier CS, *Cost-sharing for specified COVID-19 testing-related services that result in an order for or administration of a COVID-19,* is not solely for professional billing. The FCRA states that the cost sharing is to be waived for the medical visit that results in an order for or administration of a clinical diagnostic laboratory test regardless of whether the medical visit is being reported by the physician or by a facility.[4]

5. **Question** – What are the reimbursement rates for the new laboratory codes that were effective October 6, 2020?

   Answer – The reimbursement rates for the new codes have yet to be published. Because CMS collects reimbursement data and discusses the codes during the annual meeting, payment rates are not available until after this process. In the interim, reimbursement rates are to be set by your local Medicare Administrative Contractor.[5]

6. **Question** – When a patient has recovered from COVID-19 infection but has residual effects and requires aftercare therapies, how would we indicate that COVID-19 was the cause but is not a current infection?

   Answer – There currently is no specific International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) code specifically for the sequela of COVID-19. Current guidance states that diagnosis code B94.8, *Sequelae of other specified infectious and parasitic diseases,* should be assigned as a secondary diagnosis code.[6]

7. **Question** – Is there a scenario where we would use Z11.59, *Encounter for screening for other viral diseases*?

   Answer – During the COVID-19 pandemic, the screening code generally is not appropriate. The ICD-10-CM Coding Guidelines which became effective October 1, 2020 state that code Z20.828, *Contact with and (suspected) exposure to other viral communicable diseases,* should be used. The Guidelines also state that the guidance will be updated with new information concerning changes in the pandemic status.[7]

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[4] Public Law No: 116-127 "Families First Coronavirus Response Act", available at https://www.congress.gov/bill/116th-congress/house-bill/6201/text (March 18, 2020)

[5] MLN Educational Tool MLN9034855, "Clinical Laboratory Fee Schedule Annual Payment Determination Process", available at https://www.cms.gov/files/document/clinical-laboratory-fee-schedule-annual-payment-determination-process.pdf (June 2020)

[6] AHA Coding Clinic® Advisor, "Frequently Asked Questions Regarding ICD-10-CM Coding for COVID-10", page 10, available at https://www.codingclinicadvisor.com/faqs-icd-10-cm-coding-covid-19 (July 22, 2020)

[7] ICD-CM-Official Guidelines for Coding And Reporting, page 31, available at: *https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2021.pdf?fbclid=IwAR34L5vPlwhbRYv6AgCFxpZX_Gt42jgLAeMncAraBPEpaW8lcvEDPbH3uVw*

Code Z11.59 is still appropriate for other viral diseases that have no specific diagnosis code, such as Hepatitis B virus (HBV).

8. **Question** – Are codes Z11.52, Z20.822 and Z86.16 only proposed at this time?

   Answer – Yes, ICD-10-CM codes Z11.52, *Encounter for screening for COVID-19*; Z20.822, *Contact with and (suspected) exposure to COVID-19*; and Z86.16, *Personal history of COVID-19,* are proposed at this time. During the September 9, 2020 ICD-10-CM Coordination & Maintenance Committee Meeting, the codes were proposed and discussed. Unfortunately, an exact release date was not provided, but the Committee has January 1, 2021 as their goal.[8]

9. **Question** – A patient comes in symptomatic for COVID-19 with no stated exposure, and the provider diagnoses an upper respiratory infection (URI) and orders a screening test for COVID. The patient does get tested for COVID and the results are documented as negative. In this scenario we DO NOT code Z20.828. Is that correct?

   Answer – The current Fiscal Year (FY) 2021 ICD-10-CM Coding Guideline '*Signs and symptoms without definitive diagnosis of COVID-19*' states that the signs and symptoms may be used as the first-listed diagnosis code. Further, the Guidelines state, "*If a patient with signs/symptoms associated with COVID-19 also has an actual or suspected contact with or exposure to COVID-19, assign Z20.828, Contact with and (suspected) exposure to other viral communicable diseases, as an additional code.*"[9]

10. **Question** – Can the ICD-10-PCS codes that were effective on 8/1/20 be assigned when services are provided prior to that date but the patient is discharged on or after 8/1/20? We are getting payor rejections on the infusions that are reported with a date of service prior to 8/1, even if the discharge is on or after 8/1.

    Answer – The International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) codes are effective for discharges on or after August 1, 2020. In the Final Rule for implementation of ICD-10 codes, CMS stated, "…implementing new code set versions effective with the date of service, which for purposes of inpatient facilities means the medical codes in effect at the time of patient discharge. For example, if a patient is admitted in September and the patient is discharged on or after the October 1 compliance date, the hospital would have to assign the codes in effect on October 1…."[10]

    CMS and the National Center for Health Statistics (NCHS) are the governing bodies of the ICD-10-PCS code set. On the 2021 ICD-10-PCS website, CMS states that the new introduction or infusion codes are available for use with discharges on or after August 1, 2020. The files weren't posted to this site until August 6, 2020,

[8] ICD-10 Coordination and Maintenance Committee Meeting, September 8-9, 2020, "Diagnosis Agenda", page 25, available at https://www.cdc.gov/nchs/data/icd/Topic-packet-September-8-9.2020.pdf (September 8-9, 2020)
[9] ICD-CM-Official Guidelines for Coding And Reporting, page 31, available at: *https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2021.pdf?fbclid=IwAR34L5vPlwhbRYv6AgCFxpZX_Gt42jgLAeMncAraBPEpaW8lcvEDPbH3uVw*
[10] Federal Register, Vol. 74, No.11, "HIPAA Administrative Simplification: Modifications to Medical Data Code Set Standards to Adopt ICD-10-CM and ICD-10-PCS", page 3336, available at https://www.govinfo.gov/content/pkg/FR-2009-01-16/pdf/E9-743.pdf (January 16, 2009)

and denials may have occurred if the payor did not have the most current updates in their claims processing system.[11]

11. **Question** – When a patient is receiving telehealth services from a hospital outpatient department (HOPD) from two different doctors within the same practice who do not have the same specialty, the doctors are permitted to bill two separate evaluation and management (E/M) codes. Based on this scenario, would the facility be able to bill two units of HCPCS code Q3014, *Telehealth originating site facility fee*?

    Answer – During one of the Centers for Medicare & Medicaid Services (CMS) stakeholders 'CMS Office Hours' calls, CMS indicated that the quantity is based upon the number of connections. For example, if there is one meeting set up and the specialists "see" the patient one after the other, then this would be a quantity of one unit of service for HCPCS code Q3014. If there are two visits set up at separate times, then it would be appropriate to report two units of service for the originating site fee. [12]

    The rationale behind this is similar to an on-site, face-to-face visit. If the patient is in one room, sees Dr. A, then Dr. B comes in, the facility would only charge for one visit. If the patient sees Dr. A, then has to go to Dr. B's office for the next visit, then there would be two visits. The difference with the situation here is that the "room" is virtual.

12. **Question** – How can facilities truly justify reporting HCPCS code Q3014 when facility cost/resources are minimal or negligible at most?

    Answer – CMS has indicated that providers should be using the HCPCS code describing the services provided. If the service provided by the facility is supportive in nature, then HCPCS code Q3014, *Telehealth originating site facility fee,* may be reported. For Calendar Year (CY) 2020, the reimbursement rate is $26.65. This helps the facility to cover costs associated with activities such as patient registration, some pre-service and post-service work by hospital staff, covering the platform used for the audio/visual call, etc.[13]

13. **Question** – When charging HCPCS code Q3014, does the charge have to be on the same day that the physician charges something like CPT® code 99441? Our nurses call the patient and do an evaluation a day prior to the physician's call.

    Answer – Unfortunately, there is no specific guidance for your scenario, so general principles should be followed. As long as the registered nurse (RN) is providing the services incident to a physician's plan of care and under the correct level of supervision, then the services may be reported on the date the service is

[11] "2021 ICD-10 PCS, COVID Update", available at https://www.cms.gov/medicare/icd-10/2021-icd-10-pcs (August 6, 2020)
[12] Centers for Medicare & Medicaid Services Outreach & Education, Coronavirus COVID-19 Stakeholder Calls, available at: https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts
[13] "COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing", pages 131-134, available at: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf (September 11, 2020)

provided. It is possible that the technical (facility charge) and professional charges are on different dates of service.[14]

14. **Question** – When billing HCPCS code Q3014, are there any instances where the patient's home address does not need to be submitted?

    Answer – Yes, there are instances where you do not need to submit the patient's home address and still be able to submit HCPCS code Q3014, *Telehealth originating site facility fee*. Both surround the usage of modifier PN, *Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital*. If you are a non-excepted provider-based department (PBD) or If you are an excepted PBD and are willing to receive the lower reimbursement of a non-excepted PBD, you may append modifier PN to the applicable services and not submit the patient's home address to the CMS Regional Office.[15]

15. **Question** – Our facility submitted the patient's address as a designated PBD. Can our facility report HCPCS code G0463? We're currently reporting HCPCS code Q3014 right now.

    Answer – You should be selecting the code which accurately describes the service provided. According to CMS, If the hospital staff provides administrative and clinical support when a distant site practitioner furnishes a telehealth service to a registered hospital outpatient, then HCPCS code Q3014, *Telehealth originating site facility fee,* would be appropriate. Typically, the hospital would bill HCPCS code G0463, *Hospital outpatient clinic visit for assessment and management of a patient,* when a professional is located in the hospital and furnishes an E/M outpatient service to a registered hospital outpatient in the hospital. Since the patient's home is serving as a relocated outpatient department of the hospital, it would be appropriate to report HCPCS code G0463 in this situation.[16]

16. **Question** – Can HCPCS code C9803 be reported when billing PLA code 0241U since this test contains other viruses that are not COVID-19?

    Answer – Yes. HCPCS code C9803, *Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) coronavirus disease [COVID-19], any specimen source,* was created to enable facilities to capture the extra expenses involved in collecting specimens during the public health emergency (PHE).[17]

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[14] MLN Matters™ "Guidance on Coding and Billing Date of Service on Professional Claims", page 2, available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE17023.pdf , (February 1, 2019)

[15] "COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing", pages 32-33, available at: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf (September 11, 2020)

[16] "COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing", page 136, available at: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf (September 11, 2020)

[17] Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program Interim Final Rule, pages 198-199, available here: https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-09608.pdf (May 8, 2020)

17. **Question** – What if the COVID-19 testing is being done at an outpatient clinic as a drive through, but the patient has an office visit that same day at a different clinic? Can CPT® 99211 be reported for the collection of the swab?

    Answer – When the service qualifies as a separately identifiable service, then it would be appropriate to report the services separately. For example, if the patient has the specimen collected at noon and has a second visit at the different location at 3:30, then it would be appropriate to report them separately. Depending upon the type of clinic, either CPT® 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. Typically, 5 minutes are spent performing or supervising these services* or C9803, *Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) coronavirus disease [COVID-19], any specimen source* would be appropriate.[18]

18. **Question** – Do you have any documents that show we can bill CPT® 99211 with a COVID-19 test in the clinic and get around the "incident to" regulations?

    Answer – While the "incident to" requirements are still in place, the flexibilities in place during the COVID-19 PHE have relaxed the supervision requirements. As long as the supervising provider is available by audio/visual means, CMS will allow the supervision to be met by this virtual presence.[19]

19. **Question** – If there are 10 patients who are having specimen collection performed, can the facility bill C9803 for each patient, or is this a charge generated daily for each respective area?

    Answer – HCPCS code C9803, *Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) coronavirus disease [COVID-19], any specimen source* is reported for each hospital outpatient from whom a specimen is collection for COVID-19 testing. The service is conditionally packaged and only receives separate payment when it is billed without another primary covered hospital outpatient service.[20]

20. **Question** – Regarding Physical Therapy (PT), Speech-Language Pathology (SLP) and Occupational Therapy (OT), it was my understanding that telemedicine therapeutic services require modifier 95. I didn't realize it is different if the patient's home is designated as a provider-based department of the hospital.

    Answer – Yes, the instructions from CMS differ depending on whether or not the service is being billed as a telehealth service or not. When the service is provided as a telehealth service, modifier 95, *Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System,*

[18] "Special Coding Advice During CVOID-19 Public Health Emergency", available at https://www.ama-assn.org/system/files/2020-05/covid-19-coding-advice.pdf (May 4, 2020)
[19] "COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing", page 75, available at: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf (September 11, 2020)
[20] "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 (September 11, 2020)

should be appended. When the service is provided between provider-based departments of the hospital, which may include the patient's home, the modifier is not necessary.[21]

21. **Question** – Would you please review the two options available for facilities to bill PT/OT/SLP?

    Answer – Option One: Determine that you will provide the services as telehealth services. The services provided must be on the CMS list of approved telehealth services. Append modifier 95, *Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System,* to the services provided using option #1.[22]

    Option Two: Designate the patient's home as a provider-based department (PBD) of the hospital, and determine which services may be provided safely and effectively as a remote service to a registered outpatient. Append modifier PN, *Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital,* or PO, *Services, procedures and/or surgeries provided at off-campus provider-based outpatient departments* to the services provided using option #2.[23]

22. **Question** - A patient is seen by audio/visual means by one family practice provider early in the day, and then has a telephone visit later in the day by another family practice provider who counsels them on COVID. Can both providers bill for their services?

    Answer – If the services do not overlap, then it may be appropriate to report the services separately. Generally, telephone services are bundled into any pre-service or post-service work for the E/M services.

    The telephone services, CPT® codes 99441-99443, include the phrase "*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*" and the telephone service would not be separately reportable if the service was related to the previous E/M or leads to another E/M service within 24 hours.

    Although there is no National Correct Coding Initiative (NCCI) edit evoked when CPT® codes such as 99213 and 99442 are reported on the same day, CMS has stated that their expectation is that providers will report the services correctly, even in the absence of NCCI or Integrated Outpatient Code Editor (I/OCE) edits.[24]

23. **Question** – Can a patient's home be designated as a PBD and the facility's emergency department use code G0463? Does this require a modifier?

    Answer – The patient's home can be designated as a provider-based department (PBD) of the hospital for emergency department (ED) services. HCPCS code G0463, *Hospital outpatient clinic visit for assessment and management of a patient,* would not be appropriate for this scenario. If the hospital staff provides

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[21] "COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing", pages 134-136, available at: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf (September 11, 2020)
[22] "COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing", page 134, available at: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf (September 11, 2020)
[23] "COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing", pages 136-137, available at: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf (September 11, 2020)
[24] National Correct Coding Initiative Edits, "National Correct Coding Initiative Announcements", available at: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index (September 3, 2020)

administrative and clinical support for a physician located at a distant site, then HCPCS code Q3014, *Telehealth originating site facility fee,* would be appropriate. If the physician is located in the hospital and the patient's home has been designated as a PBD, then the ED visit codes may be reported utilizing either CPT® codes 99281-99285 or HCPCS codes G0380-G0384. CMS expects providers to use the E/M code that best describes the nature of the care they are providing, regardless of the physical location or status of the patient.[25]

The facility would not need to use modifier 95, *Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System*, but any other applicable modifiers would be necessary.

24. **Question** – CPT® code 95806 is a home study. The patient usually comes to the hospital, picks up the equipment and is provided the education. The patient goes home, is monitored and the physician provides a report. Is there anything different a facility needs to do to bill 95806 if the vendor is sending the equipment to the patient's home and the education, monitoring and physician's report are done remotely?

    Answer – For the facility to provide the services remotely, the patient's home will need to be designated as a temporarily relocated provider-based department (PBD) of the hospital. The service is not on the CMS list of approved telehealth services, and is not eligible to be provided as a telehealth service, so it must be provided face-to-face, which may be accomplished when the patient's home is designated as a PBD.[26]

25. **Question** – My facility is a Rural Health Center (RHC). My providers have been doing a combination of telehealth and face-to-face visits with their patients. Do we need to bill the Q3014 instead of an E/M for our telehealth visits?

    Answer – For RHCs, HCPCS code G2025, *Payment for a telehealth distant site service provided by a rural health clinic (RHC) or federally qualified health center (FQHC) only,* was created on January 27, 2020 and would be used in place of HCPCS code Q3014, *Telehealth originating site facility fee.* Modifier CG, *Policy criteria applied,* should be appended. Modifier 95, *Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System,* may be appended, but is not required. Any other applicable modifiers, such as CR or CS, should also be appended. Additionally, CMS recommends a revenue code within range 052X, *Freestanding Clinic*.

    Claims will be paid at the RHC's all-inclusive rate (AIR) of $92.03. This rate was not in the claims processing systems until after July 1, 2020, so any claims submitted between January 27 and June 30, 2020 will be reprocessed beginning on July 1, 2020.

[25] Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, page 19, available at: https://www.cms.gov/files/document/covid-final-ifc.pdf (March 30, 2020)
[26] "COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing", page 131, available at: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf (September 11, 2020)

You may wish to review MLN Matters® article SE20016 '*New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE)*' to review additional flexibilities that are specific to RHC providers.[27]

[27] MLN Matters™ "New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE)", pages 2-3, available at https://www.cms.gov/files/document/se20016.pdf , (July 6, 2020)