# A Walkthrough of Recent COVID-19 Coding & Billing Updates

# February 4, 2021

# Webinar FAQ Document

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1. **Question** – Can you please advise on the appropriate revenue code for the monoclonal antibody administration charges, such as bamlanivimab and the casirivimab and imdevimab drugs?

Answer – In order for payers to reimburse an item or service, the item or service needs to be a benefit. The Centers for Medicare & Medicaid Services (CMS) did not create a new benefit for the monoclonal antibody drugs used to treat COVID-19. Instead, they added COVID-19 medication treatments and vaccines to the existing Medicare Vaccine Benefit. The Monoclonal Antibody COVID-19 Infusion site states, “During the COVID-19 public health emergency (PHE), Medicare will cover and pay for these infusions (when furnished consistent with their respective EUAs) the same way it covers and pays for COVID-19 vaccines.”[[1]](#footnote-1)

Even though these two drugs are infusions and revenue code 0260, *IV Therapy - General Classification,* makes more sense, the CMS subject matter experts (SMEs) stated during the CMS Office Hours Calls that claims should follow the same guidelines as vaccines. According to Chapter 18 of Pub. 100-04 (The Medicare Claims Processing Manual), revenue code 0771, *Preventive Care Services - Vaccine Administration* is required. Although the medications are infusions, the policy benefit where they are housed directs revenue code assignment for Medicare beneficiaries.[[2]](#footnote-2)

1. **Question** – We are receiving Return To Provider (RTP) claims for the COVID-19 vaccine claims, stating we need to submit on paper. Have you heard if we can use our regular EPIC system to send single claims or roster bills? Also, can you confirm that revenue code 0771 is appropriate when reporting these services?

Answer – On the Medicare Billing for COVID-19 Vaccine Shot Administration page, the instructions on submitting an institutional claim state that the electronic submission is available through direct data entry (DDE), or that paper claims are acceptable. It is possible that your EPIC system could be configured to submit claims through your Medicare Administrative Contractor’s (MAC’s) DDE system. At this time, it appears that using DDE or paper claims is required.[[3]](#footnote-3)

Revenue code 0771, *Preventive Care Services - Vaccine Administration* is correct, according to the Medicare Vaccine Benefit instructions. Additionally, any other appropriate codes should be used, such as condition codes and/or modifiers.[[4]](#footnote-4)

1. **Question** – Is it true that we need to be using condition code A6 on the claims in addition to the vaccine diagnosis codes?

Answer – Yes, you would need to use condition code A6, *VACCINES/MEDICARE 100% PAYMENT,* on single claims, or condition code M1, *PAYER CODE,* if submitting a roster bill. Because CMS has placed the medications and vaccines under the Medicare Vaccine Benefit, you will want to follow the same process you use when submitting a claim for influenza or pneumococcal vaccines, including the infusion of bamlanivimab or the casirivimab and imdevimab combination drug. Additionally, any other appropriate condition codes and/or modifiers should be used.[[5]](#footnote-5)

1. **Question** – Is prior authorization required to administer bamlanivimab?

Answer – Medicare does not require prior authorization for the administration of bamlanivimab. Bamlanivimab has been given Emergency Use Authorization (EUA) by the U.S. Food & Drug Administration (FDA), which is different from the normal approval. After the public health emergency (PHE) ends, the drug will no longer be approved for use.[[6]](#footnote-6)

1. **Question** – Are we to use the regular infusion CPT® codes, such as 96365 for administration of bamlanivimab and the casirivimab/imdevimab?

Answer – There are specific Healthcare Common Procedure Coding System (HCPCS) codes for reporting the infusions. HCPCS code M0239, *Intravenous infusion, bamlanivimab-xxxx, includes infusion and post administration monitoring,* and M0243, *Intravenous infusion, casirivimab and imdevimab includes infusion and post administration monitoring,* have been created for the infusion and a one-hour post-administration monitoring period. These administration codes do not need to follow the injection/infusion hierarchy, as CMS is considering these drugs to be part of the Medicare Vaccine Benefit.[[7]](#footnote-7)

1. **Question** – Can the monoclonal antibody therapy drugs for COVID-19 be used on a patient that is an inpatient and then be billed on an outpatient claim? We thought those were for non-hospitalized patients.

Answer – Monoclonal antibody therapy drugs administered under the COVID-19 Infusion Program must be administered in accordance with the Emergency Use Authorization (EUA). The EUA specifically states that bamlanivimab and casirivimab/imdenivimab are not authorized for use in patients who are hospitalized due to COVID-19. However, this was discussed during the December 8, 2020 CMS Office Hours call, at which time the CMS subject matter experts stated that monoclonal antibody infusions would be treated similarly to the influenza vaccine when given to inpatients. On the rare occasion when monoclonal antibody therapy is administered to an inpatient who would benefit from the infusion but who is hospitalized for a condition other than COVID-19, the infusion should be reported on bill type 012X, *INPATIENT HOSPITAL (MEDICARE PART B ONLY)*.[[8]](#footnote-8)

1. **Question** – Do we need to bill M0239and M0243with their own administrative codes for payment?

Answer – HCPCS codes M0239, *Intravenous infusion, bamlanivimab-xxxx, includes infusion and post administration monitoring, and M0243**, Intravenous infusion, casirivimab and imdevimab includes infusion and post administration monitoring,* have been created to report the infusion and a one-hour post-administration monitoring period*.* The administration codes should be reported on the claim. The corresponding drug codes, Q0239, *Injection, bamlanivimab-xxxx, 700 mg,* and Q0243, *Injection, casirivimab and imdevimab, 2400 mg*, do not need to be on the claim until the facility is no longer receiving the drugs at no cost.[[9]](#footnote-9)

1. **Question** – Does Q0239 include saline mix? The description does not state it, but normally, it is used to mix the drug and infuse with.

Answer – The labeling information states that it is a sterile, preservative-free, clear to opalescent and colorless to slightly yellow to slightly brown solution in a single-dose vial for intravenous infusion after dilution. Each milliliter (mL) contains 35 mg of bamlanivimab, and L-histidine (0.4 mg), L-histidine hydrochloride monohydrate (0.6 mg), sodium chloride (2.9 mg), sucrose (60 mg), polysorbate 80 (0.5 mg), and water for injection. It does appear to contain saline (sodium chloride and water).[[10]](#footnote-10)

1. **Question** – Does M0243 need to have a stop time documented for the infusion? What do we report if we don’t have the stop time?

Answer – CMS guidance does not specifically state that a start time and stop time must be documented, but does state that appropriate medical documentation should support the medical necessity of the service, and include documentation supporting the terms of the EUA. The name of the ordering practitioner should be included. Because HCPCS codes M0239, *Intravenous infusion, bamlanivimab-xxxx, includes infusion and post administration monitoring, and M0243, Intravenous infusion, casirivimab and imdevimab includes infusion and post administration monitoring,* include the infusion and at least one hour of post-administration observation, you would need to have some time elements documented to ensure that the one-hour mark is met. If you do not have stop times documented, please contact your Medicare Administrative Contractor (MAC) for guidance*.*[[11]](#footnote-11)

1. **Question** – Do we need to disclose the drug charge for HCPCS code Q0239 or Q0243 as informational when billing for the administration? If so, how do we bill for Q0243? Would this be on separate lines with each National Drug Code (NDC)? CMS billing instructions state not to include the drugs, but not sure if all payers will follow suit.

Answer – CMS has stated that their preference is that claims do not contain the codes for the drugs as long as the drugs are provided free of charge during the current public health emergency (PHE). However, they recognize that existing payer edits may make this difficult and will therefore allow a nominal charge to be billed for the drug. There is expected to be additional guidance forthcoming once the current PHE is declared over. Unfortunately, payers may make their own rules. You would need to contact the payer to request information on their claims processing requirements.[[12]](#footnote-12)

1. **Question** – What diagnosis code would you recommend using for billing the bamlanivimab infusion?

**Answer** – Because CMS is treating HCPCS codes M0239, *Intravenous infusion, bamlanivimab-xxxx, includes infusion and post administration monitoring,* and M0243*, Intravenous infusion, casirivimab and imdevimab includes infusion and post administration monitoring,* as part of the Medicare Vaccine Benefit, ICD-10-CM code Z23, *Encounter for immunization,* should be used in addition to U07.1, *COVID-19*. Several Medicare Administrative Contractors (MACs) have posted this guidance on their websites. You may wish to double-check with your local MAC or other payer to determine if the diagnosis needs to be primary or secondary, as there are differences between the MACs.[[13]](#footnote-13)

1. **Question** – Is the information regarding the intravenous infusion hierarchy applicable to the COVID-19 monoclonal antibody infusions?

Answer – This was discussed during the December 22, 2020 CMS Office Hours call. The CMS subject matter experts stated that the use of revenue code 0771, *Preventive Care Services - Vaccine Administration,* would earmark the administration codes as vaccine administration codes, so they shouldn’t interfere with infusions. During the CMS Office Hours calls, the subject matter experts have stated that they are planning on updating the CMS FAQ documents with the information, but no update for this scenario has yet been released.[[14]](#footnote-14)

1. **Question** – Are there special codes for administering convalescent plasma to COVID-19 patients?

Answer – Yes; there are two new ICD-10-PCS codes for reporting the administration of convalescent plasma. They are:

XW13325, *Transfusion of Convalescent Plasma (Nonautologous) into Peripheral Vein, Percutaneous Approach, New Technology Group 5*; and

XW14325, *Transfusion of Convalescent Plasma (Nonautologous) into Central Vein, Percutaneous Approach, New Technology Group 5.*

Both codes became effective on August 1, 2020. The EUA for convalescent plasma allows for the administration on an inpatient basis; therefore, only ICD-10-PCS codes were developed. There are no CPT/HCPCS codes for reporting COVID-19 convalescent plasma on an outpatient basis at this time.[[15]](#footnote-15)

1. **Question** – Can you provide any billing guidelines for the administration of COVID-19 convalescent plasma?

Answer – According to the EUA for convalescent plasma, this treatment is allowed for use on an inpatient basis only. Additionally, the EUA has recently been updated so that only convalescent plasma blood products labeled as high titer are to be used, and those labeled low titer are now considered investigational.[[16]](#footnote-16)

COVID-19 convalescent plasma is eligible for the New COVID-19 Treatments Add-on Payment (NCTAP). The presence of the ICD-10-PCS codes for the administration of convalescent plasma (XW13325, XW14325) and ICD-10-CM code U07.1, *COVID-19,* will trigger the NCTAP for discharges on or after November 2, 2020. Additionally, any other appropriate items necessary for claims submission should be used, such as condition codes.*[[17]](#footnote-17)* Other data elements necessary for claims submission remain unchanged. You would still use any appropriate revenue codes, condition codes, etc., as necessary.

1. **Question** – Should hospitals be charging for convalescent plasma collection, or is it still considered to be investigational? Also, can the thawing of the plasma be separately charged?

Answer – The U.S. Food & Drug Administration (FDA) has recently updated the EUA for COVID-19 convalescent plasma. This approval letter states that collection must go through a registered or licensed blood collection establishment. The plasma that is labeled as low titer is now considered investigational, while plasma labeled as high titer is approved. The approved tests for checking the titer, as well as the titer rates, are available in the EUA approval letter.[[18]](#footnote-18) If the plasma is not investigational and your facility is a registered or licensed blood collection establishment, then you may charge for the collection.

There is no specific guidance that states you should not charge for the thawing of the plasma. The intent of the EUA and NCTAP is to have COVID-19 treatments available to patients, and current regulations are adding to the availability of the product. The regulations have not changed existing guidance for charging for blood products, so you may charge for the thawing, according to your normal charging practices. The EUA approval letter states that once thawed, the blood must be used within 5 days but does not address charges.[[19]](#footnote-19)

1. **Question** – What CPT® code would you use for an asymptomatic COVID-19 test? Is there a specific code for a COVID-19 rapid result test?

Answer – Code selection is not based upon whether the laboratory test is performed on asymptomatic patients, nor on the amount of time is takes to obtain results. Code selection is based on the type of test, such as immunoassay or nucleic acid, and the specific number of targets listed within the description. Also, Proprietary Laboratory Analyses (PLA) codes are only able to be reported when the analysis performed fulfils the code descriptor and is the test represented by the proprietary name found in Appendix O of the CPT® book. Currently, there are 300 laboratory tests and collection devices given EUA approval for COVID-19 testing.[[20]](#footnote-20)

1. **Question** – Is there a HCPCS code for remdesivir?

Answer – The current EUA for remdesivir is approved for use only on an inpatient basis. HCPCS codes are not used on inpatient claims, so no HCPCS code has been created. The administration of remdesivir has ICD-10-PCS codes, which were effective August 1, 2020. They are:

XW033E5, *Introduction of Remdesivir Anti-infective into Peripheral Vein, Percutaneous Approach, New Technology Group 5*; and

XW043E5*, Introduction of Remdesivir Anti-infective into Central Vein, Percutaneous Approach, New Technology Group 5.*

The drug has been designated as eligible for NCTAP payment, and should be reported with ICD-10-CM code U07.1, *COVID-19,* to receive the add-on reimbursement.[[21]](#footnote-21)

1. **Question** – Is Original Medicare providing coverage for screening COVID-19 testing when the patient is asymptomatic without a known exposure?

Answer – If the patient is being screened as part of a pre-surgical testing package, then the services are considered part of the pre-surgery work and reimbursement is packaged into payment for the surgical procedure.[[22]](#footnote-22)

As part of the Interim Final Rule with Comment (IFC) published in the May 8, 2020 Federal Register, for the duration of the PHE for COVID-19 CMS has removed the requirement that the clinical diagnostic laboratory tests for COVID-19 and certain related viruses must be ordered by a treating physician or non-physician practitioner (NPP) who uses the tests in the management of the patient’s specific medical problem. As part of the IFC published in the September 2, 2020 Federal Register, CMS revised this policy by specifying that each beneficiary may receive Medicare coverage for one COVID-19 and related test without the order of a physician or other health practitioner, but Medicare will require such an order to cover further COVID-19 and related tests.[[23]](#footnote-23)

During the public health emergency (PHE), it is to be assumed that everyone has been exposed to the COVID-19 virus.[[24]](#footnote-24)

1. **Question** – Did you forget the Moderna vaccine?

Answer – There is a slide with the Moderna vaccine and administration CPT® codes. When attempting to erase the notation marks from the Pfizer vaccine, the slide was skipped. The CPT® codes are:

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*;

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*; and

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*.[[25]](#footnote-25)

1. **Question** – If the patient is asymptomatic with no known exposure, what ICD-10-CM code would you use? Why is the screening code Z11.52, *Encounter for screening for COVID-19,* not used?

Answer – Current coding guidance states that ICD-10-CM code Z20.822, *Contact with and (suspected) exposure to COVID-19,* should be reported. During a wide-spread pandemic, it is to be assumed that everyone has had exposure to the virus.[[26]](#footnote-26) After the pandemic is ended, then the expectation is that coding guidance will change.

Previous coding guidance published in the *Coding Clinic® for ICD-10*, *Second Quarter 2020* has been superseded with this more current guidance, as published in the *Coding Clinic® for ICD-10, Third Quarter 2020*. ICD-10-CM code Z03.818, *Encounter for observation for suspected exposure to other biological agents ruled out,* would not be used at this time.[[27]](#footnote-27)

1. **Question** – If the patient comes into the emergency department with signs and symptoms and the COVID-19 test is negative, would you code the signs and symptoms along with Z208.22?

Answer – Current sequencing guidance states you would list the presenting signs and symptoms. ICD-10-CM code Z20.822, *Contact with and (suspected) exposure to COVID-19*, should be listed as a secondary diagnosis code during the current PHE, as it is to be assumed that everyone has been exposed to the COVID-19 virus during the pandemic.[[28]](#footnote-28)

1. **Question** – If a patient has symptoms of COVID-19 and the provider sends them for testing, do we code only the symptoms, only the screening, or both?

Answer – Current ICD-10-CM guidance states that only confirmed cases of the virus are coded with U07.1, *COVID-19*, so if you have access to positive test results or if the attending provider has documented a confirmed diagnosis of COVID-19, you may assign ICD-10-CM code U07.1. Current sequencing guidance states you would list the presenting signs and symptoms when the patient has a negative or inconclusive test result or if the test results are unknown. ICD-10-CM code Z20.822, *Contact with and (suspected) exposure to COVID-19*, should be listed as a secondary diagnosis code during the current PHE, as it is to be assumed that everyone has been exposed to the COVID-19 virus during the pandemic. You would not use code Z11.52, *Encounter for screening for COVID-19*, as guidance states this screening diagnosis is not appropriate to use during the pandemic and updated guidance will be published at a later date.[[29]](#footnote-29)

1. **Question** – We are experiencing a lot of return to provider (RTP) claims for Medicare patients who received the bamlanivimab infusion. We have been billing HCPCS codes M0239 and M0243with ICD-10-CM code U07.1, *COVID-19*. Our billing department received information that perhaps ICD-10-CM code Z23, *Encounter for immunization,* should be used. Is there guidance from CMS?

Answer – The guidance from CMS has been that the monoclonal treatments and vaccines will fall under the umbrella of the Medicare Vaccine Benefit, and claims should be submitted in the same manner as an influenza injection. CMS has left the local MACs in charge of publishing specific guidance on their websites. The local MACs are stating that ICD-10-CM Z23, *Encounter for immunization,* should be on the claim, as well as the appropriate condition code. Please be sure to check with your local MAC, as there is varying guidance.[[30]](#footnote-30)

1. **Question** – How do we code for a long-hauler with a negative COVID-19 test. Do we code it as history?

Answer – Current ICD-10-CM Coding Guidelines state that Z09, *Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm*, followed by Z86.16, *Personal history of COVID-19*, would be assigned for follow-up visits after the COVID-19 infection has resolved, and the test results are negative.[[31]](#footnote-31)

1. **Question** – Is there any ICD-10-CM code for “status post COVID-19 vaccination”?

Answer – No, there is no specific ICD-10-CM code specific to a patient who is post-COVID-19 vaccination. As codes and coding guidelines evolve, a diagnosis may become available.

1. **Question** – When providers document “post-COVID-19 syndrome,” is it appropriate to code as sequela, or is there a certain duration the patient should be COVID-19 positive?

Answer - Facilities are seeing more difficult scenarios for coding sequelae, manifestations and or complications of COVID-19 as the pandemic continues. Due to the evolution of COVID-19 and our limited understanding of how it affects the body, endless scenarios for presenting symptoms make the creation of general coding guidance a struggle, as each case creates new variables to consider. In the meantime, with limited available guidance, code selection will remain difficult.  As the COVID-19 pandemic continues, additional codes and code reporting guidelines will become available to aid in code selection.

Assign the code for the condition being treated, such as the residual cough, as the principal diagnosis, followed by code B94.8, *Sequelae of other specified infectious and parasitic diseases*. In this case, the patient no longer has COVID-19 and the cough is a residual effect (sequelae). There is no specified duration the person had to have the COVID-19 disease nor a duration after COVID-19 has resolved that would be involved in code selection. The documentation should support the causal effect between the two codes.[[32]](#footnote-32)

A personal history code is not appropriate because as stated in guideline I.C.21.c.4, “Personal history codes explain a patient’s past medical condition that no longer exists and is not receiving any treatment, but that has the potential for recurrence, and therefore may require continued monitoring.” In your scenario, the patient is clearly receiving treatment for the residual effects of COVID-19.[[33]](#footnote-33)

1. **Question** – If a patient currently has a positive COVID-19 test, plus past history, should we code for both?

Answer – For your scenario, you would assign ICD-10-CM code U07.1, *COVID-19,* and not report the personal history. The current guidelines state in guideline I.C.21.c.4, “Personal history codes explain a patient’s past medical condition that no longer exists and is not receiving any treatment, but that has the potential for recurrence, and therefore may require continued monitoring.” Because the patient is currently receiving treatment for COVID-19, the additional code for personal history would not be needed.[[34]](#footnote-34)

1. **Question** – Can ICD-10-CM code B94.8, *Sequelae of other specified infectious and parasitic diseases,* be used for the late effects of COVID-19 when M35.81, *Multisystem inflammatory syndrome,* has not been confirmed, or would Z20.822, *Contact with and (suspected) exposure to COVID-19,* be appropriate?

Answer – You would code the condition being treated, followed by ICD-10-CM code B94.8, *Sequelae of other specified infectious and parasitic diseases*. In the *Coding Clinic® for ICD-10 Third Quarter 2020* “Frequently Asked Questions Regarding ICD-10-CM Coding for COVID-19,” guidance states that codes for the condition being treated should be assigned, followed by the sequelae code, but does not reference using ICD-10-CM code Z20.822, *Contact with and (suspected) exposure to COVID-19*.[[35]](#footnote-35)

1. **Question** - How do we code the results if it states “indeterminate?” Would that be coded as a positive result?

Answer: Only confirmed cases of COVID-19, as documented by the provider or through a positive test result, are to be coded. If the provider documents "suspected," "possible," "probable," or “inconclusive” COVID-19, do not assign code U07.1. Note that confirmation does not require documentation of a positive test result; the provider’s documentation is sufficient. Instead, code the signs and symptoms reported, along with ICD-10-CM code Z20.822, *Contact with and (suspected) exposure to COVID-19*.[[36]](#footnote-36)

1. **Question** - A patient had COVID-19 several weeks ago and was treated on an inpatient basis. Three weeks later, there is a separate admission for pneumonia. The patient’s rapid screening test was positive. The providers say it isn’t COVID-19-related and not to use ICD-10-CM code U07.1 as the primary diagnosis. Does this sound right to you?

Answer – It’s possible. There are reports that indicate the patient have a positive COVID-19 test while the residual particles of the disease process through tissues and are sloughed off. The provider is responsible for diagnosing the patient’s conditions, and his/her documentation should be used when assigning diagnosis and procedure codes. Abnormal findings, including positive laboratory tests, are not coded and reported unless the provider indicates their clinical significance.[[37]](#footnote-37)

1. **Question** – If a patient has infective myocarditis due to COVID-19, should you add ICD-10-CM code B97, *Viral agents as the cause of diseases classified elsewhere*, or would you report ICD-10-CM codes U07.1, *COVID-19,* and I40.0, *Infective myocarditis*?

Answer – If the initial COVID-19 infection has resolved, you would assign ICD-10-CM code I40.0, *Infective myocarditis,* as the principal diagnosis and B94.8, *Sequelae of other specified infectious and parasitic diseases,* as a secondary diagnosis. If the patient is still being treated for COVID-19, then you would report a principal diagnosis code of U07.1, *COVID-19,* with an additional diagnosis code of I40.0, *Infective myocarditis*.[[38]](#footnote-38)

1. **Question** – Is there a special code for adverse effects of COVID-19 vaccination?

Answer – There is no specific ICD-10-CM code for adverse effects of COVID-19 vaccination. When coding an adverse effect of a COVID-19 vaccination that has been correctly prescribed and properly administered, you should assign code(s) to describe the specific adverse reaction followed by ICD-10-CM code T50.B95, *Adverse effect of other viral vaccines.*[[39]](#footnote-39)

1. **Question** – Can you please provide where to find the instructions for hospitals to submit the Medicare patient addresses to the regional offices so we can be paid for telehealth visits?

Answer – CMS states that when the facility is temporarily relocating an off-campus provider-based department of the hospital to the patient’s home, only one relocation request is needed for the duration of the PHE. You may combine requests.[[40]](#footnote-40) A list of email addresses for the CMS Regional Offices may be found here:

<https://www.cms.gov/Medicare/Coding/ICD10/CMS-Regional-Offices>

1. **Question** – From a CPT® coding perspective, what are the current guidelines for remote monitoring of patients?

Answer - CPT® codes 99453, *Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), set-up and patient education on use of equipment*, and 99454,  *Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days*, may be reported by hospital outpatient departments (HOPDs) in accordance with guidance published by CMS and with the Official Coding Guidelines for remote physiologic monitoring (RPM).

According to guidelines found in the “Remote Physiologic Monitoring Treatment Management Services” subsection, RPM services are provided when clinical staff, physicians, or other qualified health care professionals use the results to manage a patient under a specific treatment plan using a medical device as defined by the FDA. Additionally, the service must be ordered by a physician or other qualified health care professional.

Additional guidance regarding use of RPM during the COVID-19 public health emergency (PHE) can be found in Transmittal R1016OTN which states, “CMS made several changes to RPM policies in response to the PHE for COVID-19. (1) We removed the requirement that there be an established patient-practitioner relationship. Both new and established patients can receive RPM services. (2) We modified the requirement that consent must be obtained prior to furnishing the RPM service. Instead, consent can be obtained at the time services are furnished and by individuals providing PM services under contract to the ordering physician or qualified healthcare professional. (3) We clarified that RPM services can be used for physiologic monitoring of patients with acute and/or chronic conditions. (4) We confirmed that RPM services can be furnished under general supervision. (5) For CPT codes 99453 and 99454, we modified the number of days that data must be collected from the required 16 days to fewer than 16 days in a 30-day period as long as the other code requirements are met.

Because remote physiologic monitoring can be used for patients with acute and/or chronic conditions, monitoring COVID-19 symptoms would be an appropriate indication so long as the other code requirements are met. At the current time, CPT® code 99453 is assigned a status indicator of V (Clinic or Emergency Department Visit) under the Outpatient Prospective Payment System. CPT® code 99454 is assigned a status indicator of Q1 (STV-Packaged Codes) under the Outpatient Prospective Payment System, meaning it is separately payable when not reported with another significant procedure or clinic visit service.[[41]](#footnote-41)

1. **Question** – What is the Most Favored Nation (MFN) rule?

Answer – An interim final rule with comment period (IFC) to implement the Most Favored Nation (MFN) Model, and create a new Medicare payment model under section 1115A of the Social Security Act (the Act) was recently released. The MFN Model was an attempt to more closely align payment for Medicare Part B drugs and biologicals with international prices, and to remove incentives to use higher-cost drugs in order to control the unsustainable growth in Medicare Part B drug spending without adversely affecting quality of care for beneficiaries.[[42]](#footnote-42)

The MFN Model tests paying comparable amounts to the lowest price, adjusted for purchasing power, paid by any country in the Organization for Economic Co-operation and Development (OECD) that has a Gross Domestic Product (GDP) per capita that is at least 60 percent of the U.S. GDP per capita. The model also tests a single add-on payment per dose and waives beneficiary cost sharing for this payment. The model was originally set to operate for seven years, from January 1, 2021, to December 31, 2027, but implementation of the program has been delayed.[[43]](#footnote-43)

1. **Question** – Where can we find that the MFN is on hold?

Answer – CMS has created a specific MFN Model website within their Innovation Center. An update on the page states, “…**the MFN Model was not implemented on January 1, 2021 and will not be implemented without further rulemaking**.”[[44]](#footnote-44) The website may be found at: <https://innovation.cms.gov/innovation-models/most-favored-nation-model>

1. Monoclonal Antibody COVID-19 Infusion, “Medicare Monoclonal Antibody COVID-19 Infusion Program Instruction” available at <https://www.cms.gov/medicare/covid-19/monoclonal-antibody-covid-19-infusion#Billing> (January 7, 2021) [↑](#footnote-ref-1)
2. Pub. 100-04 Medicare Claims Processing Manual, Chapter 18 Preventive and Screening Services, Subsection 10.2.2

“Claims Submitted to MACs Using Institutional Formats”, pages 35-36,

available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18pdf.pdf> (October 3, 2016) [↑](#footnote-ref-2)
3. Medicare Billing for COVID-19 Vaccine Shot Administration “How to submit institutional claims”, available at <https://www.cms.gov/medicare/covid-19/medicare-billing-covid-19-vaccine-shot-administration> (January 27, 2021) [↑](#footnote-ref-3)
4. Pub. 100-04 Medicare Claims Processing Manual, Chapter 18 Preventive and Screening Services, Subsection 10.2.2

“Claims Submitted to MACs Using Institutional Formats”, pages 35-36,

available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18pdf.pdf> (October 3, 2016) [↑](#footnote-ref-4)
5. Pub. 100-04 Medicare Claims Processing Manual, Chapter 18 Preventive and Screening Services, Subsection 10.2.2

“Claims Submitted to MACs Using Institutional Formats”, page 56,

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