


COVID-19 PHE Documentation, Coding and Billing Update


Promoting Patients before Paperwork during the Public Health Emergency

April 17, 2020




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Today's Presenters




Kathy Pride




Tiffani Bouchard



Sandy Brewton



Donna Richmond



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A big THANK YOU to all healthcare workers risking their lives to save others!



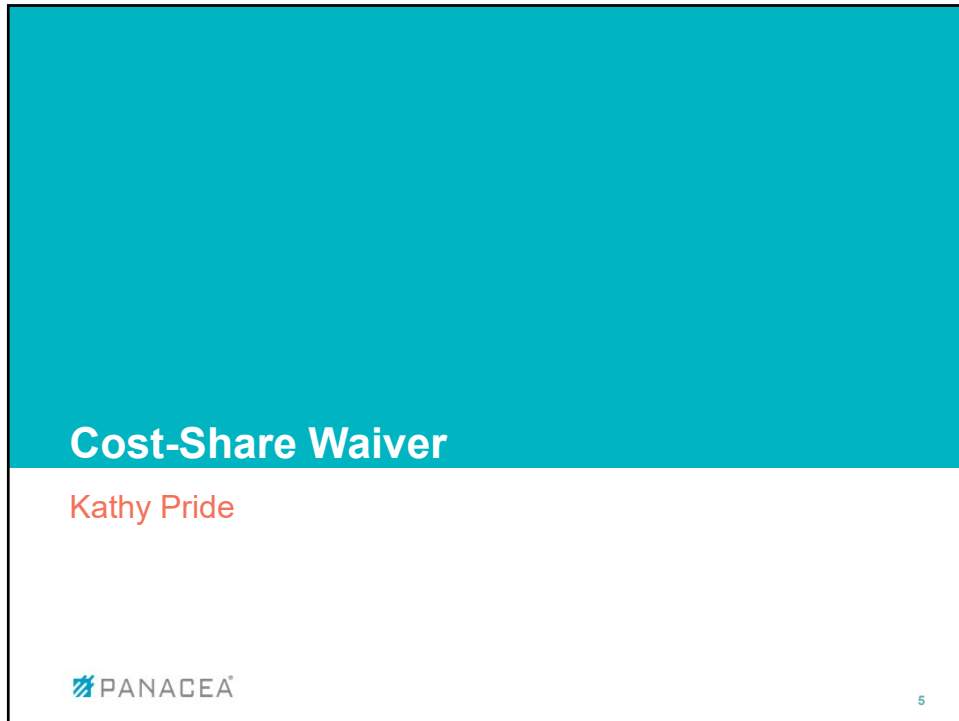
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Agenda

The following topics will be covered as they apply to the Public Health Emergency (PHE) and COVID-19:


- Waiver / Reduction in copayment
- Telehealth
- Physician Supervision Rules
- ICD-10-CM Coding for COVID-19
- Laboratory Coding for COVID-19

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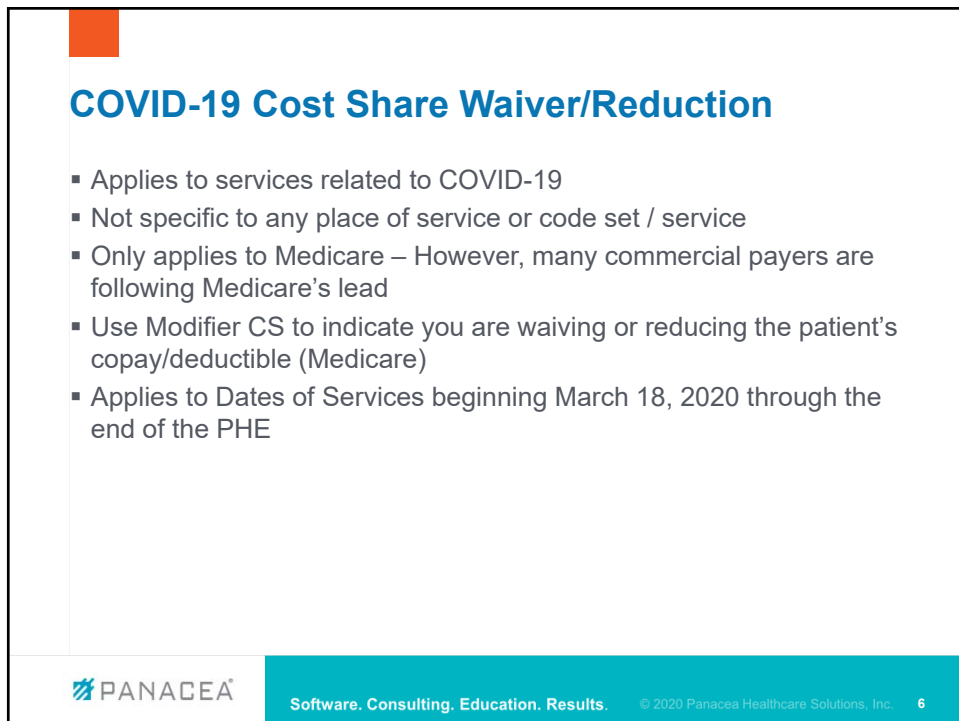
Cost-Share Waiver

Kathy Pride

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COVID-19 Cost Share Waiver/Reduction

- Applies to services related to COVID-19
- Not specific to any place of service or code set / service
- Only applies to Medicare – However, many commercial payers are following Medicare's lead
- Use Modifier CS to indicate you are waiving or reducing the patient's copay/deductible (Medicare)
- Applies to Dates of Services beginning March 18, 2020 through the end of the PHE

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Coinsurance and Deductibles COVID-19 Related Services

- The Families First Coronavirus Response Act waives cost-sharing under **Medicare Part B** (coinsurance and deductible amounts) for Medicare patients for COVID-19 testing-related services.
- Includes medical visits for the evaluation and management:
 - Result in an order for or administration of a COVID-19 test
 - Related to furnishing or administering a COVID-19 test
 - Or to evaluate an individual for the purpose of determining the need for such test
- Includes the administration of COVID-19 lab test U0001, U0002, or 87635



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Coinsurance and Deductibles COVID-19 Related Services

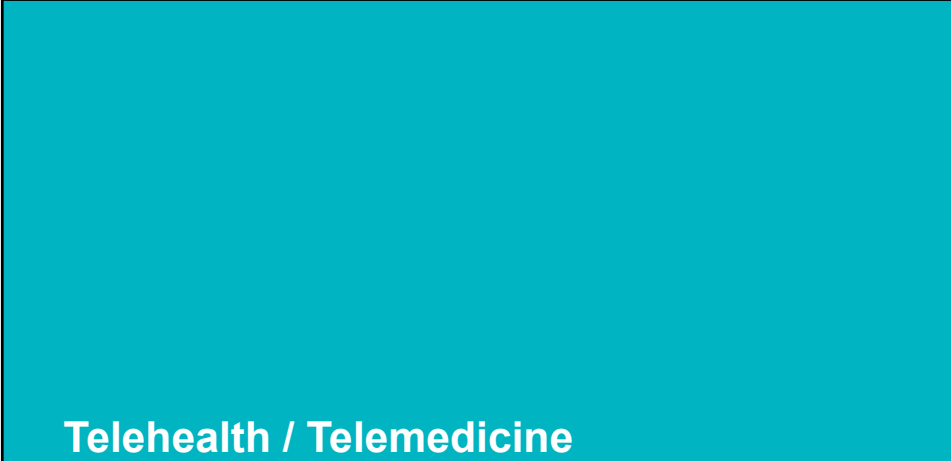
- For professional claims, physicians and practitioners who did not initially submit claims with the CS modifier must notify their Medicare Administrative Contractor (MAC) and request to resubmit applicable claims with dates of service on or after 3/18/2020 with the CS modifier to get 100% payment.
- For institutional claims, providers, including hospitals, CAHs, RHCs, and FQHCs, who did not initially submit claims with the CS modifier must resubmit applicable claims submitted on or after 3/18/2020, with the CS modifier to visit lines to get 100% payment.

Source: <https://www.cms.gov/outreach-and-education/outreachffsprovpartprogprovider-partnership-email-archive/2020-04-07-mlnc-se>




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Telehealth / Telemedicine

Kathy Pride




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Traditional Telehealth and Telemedicine

- Requires patient to be at an originating site (e.g. rural clinic or hospital) – **This is requirement is waived during the PHE**
- Distance provider uses HIPAA compliant telecommunication technology to interact with the patient to provide the service(s)
- Only a discrete set of services allowed such as (this is not an all-inclusive list):
 - Established patients only
 - Office Visits (99212-99215) (telehealth)
 - Telehealth consultations, emergency department or inpatient (G0425-G0427) (telehealth)
 - E-visits patient initiated through **an online patient portal** (99421 – 99423) (G0261-G0262) (telemedicine)
 - Brief check-ins initiated by patient calling the provider (G2012) (telemedicine)



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Facility Reporting for Telehealth

- **Q: Can hospitals, nursing homes, home health agencies or other healthcare facilities bill for telehealth services?**
- **A:** Billing for Medicare telehealth services is limited to professionals. (Like other professional services, Critical Access Hospitals can report their telehealth services under CAH Method II). If a beneficiary is in a health care facility (even if the facility is not in a rural area or not in a health professional shortage area) and receives a service via telehealth, the health care facility would only be eligible to bill for the originating site facility fee, which is reported under HCPCS code Q3014. But the professional services can be paid for.



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Non-Traditional Telehealth During the PHE

- Beginning March 1, 2020 through the end of the declared PHE including subsequent renewals:
 - Can be New or Established patient
 - Evaluation and Management (E&M) Visits from any location (must be real time audio-visual visits)
 - Telephone calls (audio only visits) 99441-99443 (telemedicine)*
 - Traditional telehealth services may be provided without the rural area designation or the patient going to an originating site.
 - Relaxed HIPAA guidelines allowing the use of smartphone and other non-traditional audio/visual telecommunication technology
 - Eliminated frequency limitations


* Temporarily Added to Physician Fee Schedule for duration of PHE



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Telehealth Requirements for E&M Visits During PHE

- Must use interactive telecommunication systems technology for **E&M Services** traditionally provided face-to-face (i.e. Face-time, Skype, etc.)
- Must document the visit was provided via audio-visual technology
- Must document consent from the patient to provide the service via a telehealth visit (may be documented by ancillary staff).
- Use Medical Decision Making (MDM) or Time as the determining factor for code selection.
 - **Use the current MDM guidelines/definition**
 - **Use Time as defined in the 2021 guidelines**
- Telephone calls (audio only) (99441-99443) Covered telemedicine service retroactive to March 1, 2020 through the end of the PHE



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Expanded Services Allowed for Telehealth During PHE

- Office and Other Outpatient (99201-99205)
- Emergency Department (99281-99285)
- Critical Care (99291-99292)
- Observation: Initial, Subsequent and Discharge (99217-99226, 99234-99236)
- Inpatient: Initial, Subsequent, and Discharge (99221-99223, 99231-99233, 99238-99239)
- Initial and Subsequent Nursing Facility (99304-99310, 99315-99316)
- Domiciliary, Rest Home, or Custodial Care (99327-99337)*
- Home Visits (99341-99350)
- Telephone Services (99441-99443) – for audio only E&M services (telemedicine)

* 99324 – 99326 were not listed in the IFR



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Expanded Services Allowed for Telehealth During PHE

- Inpatient Neonatal and Pediatric Critical Care (99477-99480)
- Care Planning for Patients with Cognitive Impairment (99483)
- Group Psychotherapy (90853)
- ESRD Services (90951-90970)
- Psychological and Neuropsychological Testing (96130-96139)
- Therapy Services (97161-97168, 97110,97112, 97116, 97535, 97750 – 97761, 92521-92524, 92507) (must be provided by an eligible practitioner)
- Radiation Treatment Management Services (77427)
- Critical Care Consultation Services (G0508-G0509)



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How To Code and Bill Non-Traditional Telehealth Services

- Use the CPT code that best describes the encounter if it would have been provided face-to-face
- Use the POS that is associated with the CPT code that best describes the encounter if it would have been provided face-to-face
- Use Modifier 95 to identify the service was provided via telehealth
- Use Modifier CR to identify telemedicine services provided for COVID-19 related services
- Use Modifier CS to identify it is a COVID-19 related E&M service, **and** you intend to waive or reduce copay



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Non-Traditional Telehealth

Example 1:
Established patient was scheduled for an office visit, but due to the PHE, the physician provided the service via Skype. The service was of low complexity:

- POS 11, 99213-95

Example 2:
A subsequent hospital visit is provided for a patient in the hospital via Face-time for a non-COVID-19 related condition. The service was of moderate complexity:
POS 21, 99232-95


REMINDER: Level of service is selected based on MDM or Time

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Physician Supervision Rules

Donna Richmond

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Physician Supervision During PHE

- “Incident to” services
 - Direct supervision can be provided using real-time interactive audio and video technology
- Direct Supervision of Diagnostic Studies furnished in an on-campus or off-campus outpatient department of a hospital can be provided using telecommunications technology
- Direct Supervision of pulmonary, cardiac and intensive cardiac rehabilitation services can be provided through audio/video real-time communications technology



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Teaching Physician Guidelines During PHE

- **Primary Care Setting** – All levels of E&M may be provided by a resident under direct supervision of the teaching physician by interactive telecommunications technology
- **E&M Services** – Residents providing E&M services, allow direct supervision of the teaching physician by interactive telecommunications technology
- **Diagnostic Radiology and Other Diagnostic Tests** – Allow interpretation by a resident under direct supervision of the teaching physician by interactive telecommunications technology, the teaching physician must still review the resident’s interpretation
- **Psychiatric Services** – Allow direct supervision of the teaching physician by interactive telecommunication technology.
- **Surgical, Endoscopic, and Anesthesia Services** – No changes to current supervision rules. Teaching physician must be physically present during key portions of the procedure



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Other Supervision Changes

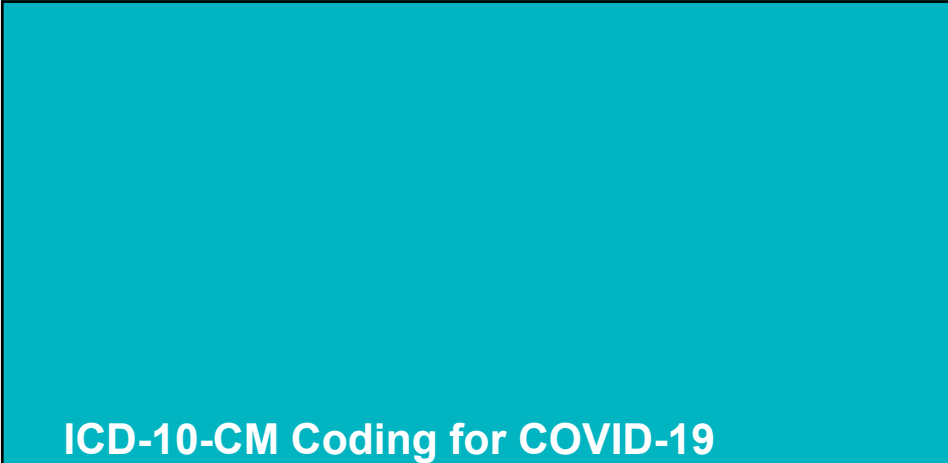
- Inpatient Rehabilitation Facilities –
 - Still require 3x per week supervision by the rehabilitation physician, but that may be done by interactive telehealth
- Non-Surgical Extended Duration Therapeutic Services (NSEDTS) -
 - Services during the initiation period have been changed from direct to general supervision during the PHE
- Critical Access Hospitals (CAHs) –
 - The requirement for physical presence of the doctor is waived during the PHE, Physician can be available ““through direct radio or telephone communication, or electronic communication for consultation, assistance with medical emergencies, or patient referral.”

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Other Supervision Changes


- Physician supervision of NPs in RHCs and FQHCs –
 - CMS is modifying the requirement that a physician must provide medical direction for, consultation and medical supervision of nurse practitioners
 - “allows RHCs and FQHCs to use nurse practitioners to the fullest extent possible and allows physicians to direct their time to more critical tasks.”

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ICD-10-CM Coding for COVID-19

Sandy Brewton




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Coding for COVID-19: Coding Clinic and CDC Guidance

- Code **confirmed** or **presumptive positive** cases of COVID-19 with the following:
 - U07.1 COVID-19
 - for services on or after April 1, 2020
 - B97.29, *Other coronavirus as the cause of diseases classified elsewhere*
 - for services on or before March 31, 2020
- Sequencing of Codes:
 - U07.1 / B97.29
 - Assign as principal or first-listed diagnosis
 - followed by the appropriate codes for associated manifestations, except in the case of newborns and obstetrics



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Coding for COVID-19: Coding Clinic and CDC Guidance

- **Pneumonia** case confirmed as due to COVID-19
 - Assign J12.89, *other viral pneumonia*
 - in addition to U07.1 / B97.29
- **Acute Bronchitis** confirmed as due to COVID-19
 - Assign J20.8, *Acute Bronchitis due to other specified organism*
 - In addition to U07.1 / B97.29
- **Lower Respiratory Infection** confirmed as due to COVID-19
 - Assign J22, *unspecified acute lower respiratory infection*
 - In addition to U07.1 / B97.29
- **Acute respiratory distress syndrome (ARDS)** due to COVID-19
 - Assign J80, *Acute respiratory distress syndrome*
 - In addition to U07.1 / B97.29

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Coding for COVID-19: Coding Clinic and CDC Guidance

- COVID-19 infection that progresses to Sepsis
 - See *Section I.C.1.d. Sepsis, Severe Sepsis, and Septic Shock*
- COVID-19 in Pregnancy, Childbirth and the Puerperium
 - See *Section I.C.15.s, COVID-19 infection in pregnancy, childbirth, and the puerperium*
 - During pregnancy, childbirth or the puerperium, a patient admitted (or presenting for a health care encounter) because of COVID-19 should receive a principal diagnosis code of O98.5-, Other viral diseases complicating pregnancy, childbirth and the puerperium, followed by code U07.1, COVID-19, and the appropriate codes for associated manifestation(s). Codes from Chapter 15 always take sequencing priority.

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Coding for COVID-19: Coding Clinic and CDC Guidance

▪ Exposure to COVID-19

- If ruled out after evaluation
 - Assign Z03.818, *Encounter for observation for suspected exposure to other biological agents ruled out.*
- Actual exposure to someone with COVID-19
 - Exposed individual tests negative or unknown
 - > Assign Z20.828, Contact with and (suspected) exposure to other viral communicable diseases

▪ Suspected COVID-19 –

- Currently, there are no other COVID-19 related ICD-10-CM codes
 - Assign Z03.818 or Z20.828 as appropriate
 - > Additionally assign signs and symptoms such as
 - R05, *Cough*
 - R06.02, *Shortness of Breath*
 - R50.9 *Fever, unspecified*



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Coding for COVID-19: Coding Clinic and CDC Guidance

▪ Screening for COVID-19


- Asymptomatic, no known exposure
 - Test results are unknown or negative
 - > Assign Z11.59, Encounter for screening for other viral diseases

▪ Do **not** use

- B34.2, *Coronavirus infection unspecified*
 - as cases have universally been respiratory in nature, so the site would not be “unspecified.”



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Coding for COVID-19: Coding Clinic and CDC Guidance

Coding clinic recommends hold back coding of admissions and outpatient encounters related to COVID-19 until results are back.

This coding guidance has been developed by CDC and approved by the four organizations that make up the Cooperating Parties: the National Center for Health Statistics, the American Health Information Management Association, the American Hospital Association, and the Centers for Medicare & Medicaid Services


Resource for Coding Guidelines: <https://www.cdc.gov/nchs/icd/icd10cm.htm>

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Laboratory Coding for COVID-19

Tiffani Bouchard

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COVID-19 Respiratory Specimen Testing

- For most hospital laboratories codes U0002 and 87635 will likely be used taking into consideration the method for the COVID-19 testing. When the CDC test kit is used, code U0001 will be billed. Hospitals will need to consider the testing method to ensure the most applicable code is reported to Medicare and commercial payers.
- We have noted many of the major payers (Aetna, UnitedHealthcare, BCBS) are allowing the U HCPCS codes for billing.

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COVID-19 Respiratory Specimen Testing

CPT / HCPCS Code	Long Description	Status Indicator	Payment
87635	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-10]), amplified probe technique	A	TBD
U0001	CDC 2019 Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel	A	\$36
U0002	2019-ncov coronavirus, sars-cov-2/2019-ncov (covid-19), any technique, multiple types or subtypes (includes all targets), non-cdc	A	\$51

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COVID-19 Respiratory Specimen Testing

- COVID-19 detection by DNA or RNA utilizing amplified probe technique will be reported using code 87635
- Per AMA coding instruction, if physician orders both nasopharyngeal swab and oropharyngeal swab and both specimens are tested then it is appropriate to report code 87635 x1 unit and 87635-59 x1 unit.



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COVID-19 Respiratory Specimen Testing

- COVID-19 detection (non-cdc) by method other than amplified probe technique will be reported using code U0002.
- At this time, we have not identified other testing methods other than CDC diagnostic panel is being used.



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COVID-19 Respiratory Specimen Testing

- COVID-19 detection using CDC diagnostic panel test kit will be reported using U0001.
- Per the CDC, this code may only be reported by laboratories who use Applied Biosystems 7500 Fast DX Real-time PCR Instrument with SDS 1.4 software.

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COVID-19 Respiratory Specimen Testing

- For COVID-19 detection using new market testing method/kit, CMS instructs laboratories that codes U0002 or 87635 are applicable for use until additional information for coding is warranted.
- Hospitals and providers following the guidance in the COVID-19 FAQs for diagnostic testing will want to reference question #6 for billing new tests.
<https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf>

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COVID-19 Respiratory Specimen Testing

- Several manufacturers (Abbott, Cepheid, BioFire, bioMerieux, GenMark Dx, Hologic, Quidel Lyra, Roche) have developed rapid testing (some may also be referred to as point of care testing) methods for COVID-19 that have been approved by U.S. Food & Drug Administration (FDA) under the Emergency Use Authorization (EAU).
- Physician offices/clinics who are performing COVID-19 testing by rapid test/kit will want to confirm with the manufacturer the testing method if not certain.



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COVID-19 Serologic Specimen Testing

The American Medical Association (AMA) created two new codes for antibody testing (serologic testing). They have indicated these codes are available for use beginning April 10, 2020. Acceptance of these codes will vary by payer, so it may be necessary to hold claims until Medicare and commercial payers have published when they will be prepared to adjudicate claims with these new codes.


- AMA has released a special edition CPT Assistant that can be viewed at the link below
<https://www.ama-assn.org/system/files/2020-04/cpt-assistant-guide-coronavirus-april-2020.pdf>



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COVID-19 Serologic Specimen Testing

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




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COVID-19 Serologic Specimen Testing

- Code 86328 is an infectious agent antibody qualitative or semiquantitative immunoassay single-step method.
- Only one unit may be reported regardless of the number of antibody classes tested with one reagent strip.
- If two distinct reagent strip assays are ordered and performed, then this may be reported as 86328 x1 and 8632859 x1.



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COVID-19 Serologic Specimen Testing

- Code 86769 is an antibody qualitative or semiquantitative immunoassay multi-step method.
- If multiple assays are ordered and performed for antibodies (different immunoglobulin classes – IgG and IgM) via two distinct multi-step analyses, then report code 86769 x1 and 8676959 x1.



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COVID-19 Serologic Specimen Testing

Code 86735 is specific to testing for COVID-19 using respiratory specimen(s) and codes 86328 and 86769 are specific to serologic specimen. If a physician orders collection of a nasopharyngeal or oropharyngeal specimen and a blood specimen and both tests are performed, then CPT codes may be reported for each distinct test.

- Report code 86328 (reagent single-step method) or 86769 (multi-step method) with code 86735 when this scenario occurs.



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COVID-19 Serologic Specimen Testing

In March, the FDA issued a policy to allow developers of certain serological tests to begin to market or use their tests once they have performed the appropriate evaluation to determine that their tests are accurate and reliable. This includes allowing developers to market their tests without prior FDA review if certain conditions outlined in the guidance document are met. The FDA issued this policy to allow early patient access to certain serological tests with the understanding that the FDA has not reviewed and authorized them.

COVID-19 Serologic Specimen Testing

- Cellex qSARS-CoV-2 IgG/IgM Rapid Test
 - Cellex qSARS-CoV-2 IgG/IgM Rapid Test is a lateral flow chromatographic immunoassay unit/reagent strip which can detect both antibodies against the SARS-CoV-2 virus
 - **CPT code 86328**

COVID-19 Serologic Specimen Testing

- Eagle Biosciences IgM ELISA Assay Kit and IgG ELISA Assay Kit
 - The Eagle Biosciences COVID-19 serology ELISA assay utilizes the microplate-based enzyme immunoassay technique
 - **CPT code 86769**

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COVID-19 Laboratory Specimen Collection

- G2023 - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source
 - CLFS \$23.46
- G2024 - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source
 - CLFS \$25.46

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COVID-19 Laboratory Specimen Collection

- While CMS has not yet published guidance for units reporting, the hospital will generally report one (1) unit for the specimen collection. The CDC recommended collection methods are via nasopharyngeal (NP) (preferred method), oropharyngeal (OP), nasal mid-turbinate (NMT) or anterior nares.
- If two methods are ordered by the physician and used to obtain specimens, then it would be appropriate to report one unit for each method.

COVID-19 Laboratory Specimen Collection

- CDC does not recommend induction of sputum. CDC does state when clinically indicated (e.g., a patient who is receiving invasive mechanical ventilation) an appropriate specimen via lower respiratory tract aspirate or bronchoalveolar lavage may be performed and tested as lower respiratory tract specimen. Under these methods, specimen collection is inclusive of these procedures and would not be separately reported.

COVID-19 Provider Specimen Collection


- Depending on the scenario for the specimen collection-- will depend on how code and bill.
- Because of the complexity (special training) required for the swab specimen collection methods, code 99000 or 99001 will be used for the specimen collection associated with the face-to-face visit or if the visit is a swab collection only visit.
- If the physician is performing the COVID-19 test (e.g., rapid test kit) in the office in addition to a face-to-face E/M, there is no separate charge for the specimen collection.

COVID-19 Testing Resources


- CMS <https://www.cms.gov/files/document/03092020-covid-19-fags-508.pdf>
- CMS <https://www.cms.gov/files/document/covid-final-ifc.pdf>
- CMS <https://www.cms.gov/outreach-and-education/outreachffsprovpartprogprovider-partnership-email-archive/2020-03-31-mlnc-se>
- AMA <https://www.ama-assn.org/system/files/2020-03/cpt-assistant-guide-coronavirus.pdf>
- AMA <https://www.ama-assn.org/system/files/2020-04/covid-19-coding-advice.pdf>
- AMA <https://www.ama-assn.org/system/files/2020-04/cpt-reporting-covid-19-testing.pdf>

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