COVID-19 Webinar Q&A Follow Up

1. *Does modifier CS apply to E&M services only or would it be applied to any service that cost sharing applies? - To clarify my original question, modifier CS wouldn't be appended to lab services that are paid under the lab fee schedule where cost sharing does not apply, right?*

   That is correct. The CS modifier would not apply to lab services. The guidance from the CMS MLN Connects Special Edition Tuesday, April 7, 2020 "COVID-19 testing-related services billed to Medicare Part B" applies to "medical visits that are furnished between March 18, 2020 and the end of the PHE, that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test; **and are in any of the following categories of HCPCS evaluation and management codes**:

   - Office and other outpatient services
   - Hospital observation services
   - Emergency department services
   - Nursing facility services
   - Domiciliary, rest home, or custodial care services
   - Home services
   - Online digital evaluation and management services"

   This can be found in the following MLN Connects link: https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-07-mlnc-se

2. *The CS modifier is only related to testing for or evaluation to determine if testing is necessary. Does it also cover all related COVID E/Ms?*

   According to MLN Connects Special Edition dated April 7, 2020: "For services furnished on March 18, 2020, and through the end of the PHE, outpatient providers, physicians, and other providers and suppliers that bill Medicare for Part B services under these payment systems should use the CS modifier on applicable claim lines to identify the service as subject to the cost-sharing wavier for COVID-19 testing-related services and should NOT charge Medicare patients any co-insurance and/or deductible amounts for those services."

   The guidance states "COVID-19 testing-related services billed to Medicare Part B" applies to "**medical visits** that are furnished between March 18, 2020 and the end of the PHE, that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes

of determining the need for such a test; **and are in any of the following categories of HCPCS evaluation and management codes**:"

For specific categories of E&M services, please see response to Question #1.
https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-07-mlnc-se

3. *I have a question regarding the CS modifier for Medicare Part B. What sort of services would get this modifier? Is it only for E/M services and labs, or would it be applied to chest xrays, chest CTs, etc.?*

   The CS modifier would not apply to radiology services. The guidance states "COVID-19 testing-related services billed to Medicare Part B" applies to "**medical visits** that are furnished between March 18, 2020 and the end of the PHE, that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test; **and are in any of the following categories of HCPCS evaluation and management codes**:"

   For specific categories of E&M services, please see response to Question #1.

   Resource: https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-07-mlnc-se

4. *For COVID related services that were billed without the CS modifier and you were paid the lower rate and the patient paid their copay, will they be asking for it back, and if we rebill with the CS will that be denied as we rebill with the CS will that be denied as duplicate claim?*

   According to MLN Connects special edition dated April 7, 2020: "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."
   https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-07-mlnc-se

Providers will need to contact their Medicare MAC for instructions on how to rebill (refile claims) and verify the process to return patient copay.

5. *When the provider uses a time-based code such as telephone call 99442, is the provider required to document time spent on the call?*

   Yes, because this is a time-based code, providers are required to document total time spent on the call.

6. *Slide 17 subq hosp visit is 99232 the code that is listed on Example #2 is for an initial hospital*

   Thank you. This was a typo in the PPT. The correct E&M should have been 99232 as you stated.

7. *We have been directed to use CR modifier during this time on telehealth and phone calls. is the CS better just for COVID related services/diagnosis?*

   According the CMS MLN Matters SE20011, the use of CR modifier is not required on telehealth services. https://www.cms.gov/files/document/se20011.pdf However, there are services provided under the 1135 Waiver that do require the CR modifier. The list is lengthy; therefore, we are providing you with the following link to review the list. This link is also embedded in the MLN Matters SE20011 link above under the heading "Blanket Waivers Issued by CMS." https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

8. *What is the guidance if an audio and video session had to be converted to audio only after it had been started as audio and video?*

   Good question, however, Medicare has not provided any guidance regarding this scenario. Panacea suggests this question be submitted to CMS directly at partnership@cms.hhs.gov.

9. *Can you please provide guidance on modifier CS? Which line items on the claim should it be appended to and provide guidance on how to determine whether to append or not. For example, if the patient is seen in the ED (institutional claim) and the patient has multiple symptoms where not only COVID 19 is being ruled out but so is a UTI, does the CS modifier get appended to the urinalysis also.*

See response for Question 1. Medicare included the verbiage "…or to the evaluation of an individual for purposes of determining the need for such a test." Therefore, if the documentation supports the patient's symptoms were evaluated to rule out COVID-19 versus another cause of infection, then we would agree that modifier CS is appropriate, even if the final diagnoses was determined to be for something other than COVID-19.

10. *If you have an ER visit and are billing the hospital technical fee only, the visit includes an evaluation for COVID, but no lab testing was warranted. Would you attach the CS modifier to the E & M code if there is no ancillary test reported with a CPT code assigned? I'd heard some rumblings about a condition code on UB's. Is there any truth to that?*

    As part of the Families First Coronavirus Response Act, "Cost-sharing does not apply for COVID-19 testing-related services, which are medical visits that: are furnished between March 18, 2020 and the end of the Public Health Emergency (PHE); that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test **or to the evaluation of an individual for purposes of determining the need for such a test…"**

    This means that CMS is allowing providers to waive copays and deductible for COVID-19 related E&M services that are related to testing including for **the purpose of determining the need for such a test.**

    CS modifier may be appended to the charge for the facility emergency room visit code if the hospital did not charge the patient any co-insurance and/or deductible amounts. In response to your second question, CMS is requiring the condition code DR on the UB form for COVID related services including but not limited to the ED facility charge.

11. *Can you please explain the use of modifier CR and how it differs from the CS modifier?*

    CR Modifier - In 2005, CMS created modifier "CR" (description: Catastrophe/disaster related) to assist MACs in processing claims as a result of Hurricane Katrina. This modifier was also authorized for use on Part B CMS-1500 claim forms for any services affected as a result of future emergencies.

    The use of modifier CR is an acknowledgement that the claim (meaning service or item) is affected by an emergency or disaster. Use of modifier CR is mandatory, with the exception of telehealth claims, for applicable CPT/HCPCS codes for which Medicare Part B payment is conditioned on the presence of a "formal waiver."

    Proper use of modifier CR:
    Modifier CR is used for Part B items and services only, but may be used in either institutional or noninstitutional billing. Use of modifier CR is required when an item or

service is impacted by an emergency or disaster and Medicare payment for that item or service is conditioned on the presence of a "formal waiver."

Some examples of claim types affected by the waiver on which you would add modifier CR:

- Claims for testing services at newly set-up swab sites
- Telephone calls (98966–98968; 99441–99443) Note: These are not telehealth services
- Providers rendering services in states in which they are not licensed
- Ambulance claims with newly approved destination modifiers
- Services by a teaching physician supervised virtually under the waiver for an in-person supervision

Use of modifier CR may also be required when either the contractor or CMS determine that such use is needed to efficiently and effectively process claims or to otherwise administer the Medicare fee-for-service program. For a complete list of all waivers see https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

NOTE: CMS is not requiring modifier CR on telehealth services (use modifier 95 for telehealth services).

CS Modifier is used to identify COVID-19 related **E&M services** that are subject to the cost-sharing waiver (waiver of copay and deductibles). The guidance from the MLN Connects special edition dated April 7, 2020 states "COVID-19 testing-related services billed to Medicare Part B" applies to "medical visits that are furnished between March 18, 2020 and the end of the PHE, that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test; and are in any of the following categories of HCPCS evaluation and management codes:

- Office and other outpatient services
- Hospital observation services
- Emergency department services
- Nursing facility services
- Domiciliary, rest home, or custodial care services
- Home services
- Online digital evaluation and management services"

12. *Where did you see that 2021 times are to be used for selection of level based on time for Telehealth?*

This is on page 136 of CMS-17744-IFC (Interim Final Rule) (IFR). "On an interim basis, we are revising our policy to specify that the office/outpatient E/M level selection for these services when furnished via telehealth can be based on MDM or time, with time defined as all of the time associated with the E/M on the day of the encounter; and to remove any requirements regarding documentation of history and/or physical exam in the medical record. This policy is similar to the policy that will apply to all office/outpatient E/Ms beginning in 2021 under policies finalized in the CY 2020 PFS final rule. It remains our expectation that practitioners will document E/M visits as necessary to ensure quality and continuity of care. To reduce the potential for confusion, we are maintaining the current definition of MDM…The typical times associated with the office/outpatient E/Ms are available as a public use file at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F
The link referred to in the IFR statement is the 2020 Physician Fee Schedule Final Rule published in November, 2019.

13. *If a provider is using only audio to provide IP consult and rounding visits. Are these billable?*

    Yes, according to the Medicare representative on the recent CMS Telehealth Q&A call, Emily Yoder, if the physician is using audio only equipment, they may bill the service using Telephone calls 99441-99443. Reference – Page 17 of the transcript from the CMS Special Open Door Forum Telehealth session April 8, 2020, that can be accessed at the following link:
    https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

14. *We have a telehealth service with a physician, APRN and patient all three on the zoom visit but most of note written by APRN. Can you bill as shared?*

    The rules for shared visits were not addressed; therefore, you must go on the premise they have not changed. For a visit to be billed as a shared visit, both providers involved must perform and document a portion of the history, exam, or medical decision making. If the telehealth encounter was in lieu of an office visit, then the rules for incident to must be met. The only change to the "incident to" guidelines that was addressed in Section E of the IFR is that direct supervision required for "incident to" to be met can be via real time audio/video telecommunications, which in your scenario is met.
    https://www.cms.gov/files/document/covid-final-ifc.pdf

15. *Question: Given a scenario where prior to the PHE, two providers (from different specialties) would treat the same patient (separately) but have a shared decision making due to the patient's condition, and have decided to now treat the patient via ONE audio-visual call, how should you code the visit? The providers are in separate locations and*

all three call/sign in. A history is obtained, exam performed as possible, and the providers discuss an impression and plan. The providers still document separate visit notes in the medical record.

This scenario was not addressed by CMS; therefore, we recommend following the rules of telehealth and document and report the services as if the patient was seen face-to-face if both providers were physically in the same room at the same time, face-to-face with the patient. Of course, they need to document their own notes including their portion of the history, virtual exam (if any) and medical decision making process.

16. *For Incident to and Shared Services. Does the provider need to be on the audio/visual at the same time?*

    The rules for shared visits were not addressed in the IFR; therefore, they have not changed. The services must be performed on the same date of service, and documentation must reflect the portion of the E&M visit performed by each provider. Shared Services do not require the providers to be in the room at the same time. However, to meet incident to guidelines via telehealth, the supervising provider must be on the audio/visual call at the same time. For additional guidance on Shared Services, send your inquiry to CMS at partnership@cms.hhs.gov.

17. *What is the recommendation/ruling for hospital outpatient therapy departments performing physical and speech therapy telehealth visits? Therapists are not listed under the provider listing and currently do not have individual NPIs because this is billed under the hospital NPI. Could/should they apply for an individual NPI under the hospital NPI?*

    Unfortunately, the news is not good for physical, occupational, and speech-language pathologists performing services in any healthcare setting. In the IFR, CMS acknowledge that the Physical Therapists, Occupational Therapists and Speech Pathologists were not considered eligible providers; therefore, are not allowed to bill for services if they were provided via telehealth. However, the therapy codes were added to allow an **eligible** distance site practitioner to bill for these services (physician, NP, PA, etc.). Reference: Page 35 of CMS-1744-IFC.

    During the CMS Telehealth Q&A conference call the CMS representative, Emily Yoder, acknowledged that CMS was aware of the restrictions imposed upon therapists, and encouraged listeners to submit their concerns to CMS for possible consideration in future rule making.

    The following is a list of **eligible** practitioners for billing telehealth services. Of note, the eligible provider is only allowed to provide services within their scope of practice:

    - Physicians

- Nurse practitioners
- Physician assistants
- Nurse-midwives
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Clinical psychologists and clinical social workers (may not bill for psychiatric diagnostic interviews or E/M services)
- Registered dietitians or nutrition professionals

18. *For the incident-to supervision, do the providers have to be online during the service on the audio-visual technology, or reachable by this technology at the time of service?*

    According to the IFR, the provider must be on the audio-visual call at the time of service.

19. *For a hospital network system, direct supervision was mentioned. We perform many procedures requiring "personal" supervision. The patients are in our hospital, as an outpatient. The attending Radiologist does not want to be in the room, or perhaps not in the facility, and only have the resident perform the actual procedure (i.e. swallowing studies, modified barium swallows, UGI's, etc...) or fluoro-guided procedures.*

    Personal supervision rules did not change. Any service such as the fluoro procedures including modified barium swallow, require physician presence in the room while the service is performed to be able to bill the technical service. So, for services performed in the hospital, the hospital cannot bill the procedure if there is not a physician present in the room. For inpatient services, if a resident is fully licensed as a physician, has his own Medicare billing number, and is acting outside his approved GME program (i.e. moonlighting), then he may provide the personal supervision, and the exam would be billed under his name/number.

20. *I missed the direction for when it's acceptable for residents to have "general supervision". It was the comment right after inpatient rehab changes.*

    It was discussed that "non-surgical extended duration therapeutic services" (NSEDTS) during the initiation period of the therapeutic services was changed from direct to general supervision. General supervision, as defined in CMS regulation at 410.32(b)(3)(i) means that the procedure is furnished under the physician's overall direction and control, but that the physician's presence is not required during the performance of the procedure.

    Changes to supervision of residents by the teaching physician were not changed except to allow the direct supervision to be provided using interactive telecommunications technology. The teaching physician must still be present via interactive

telecommunications during the key portions of the service. For E&M visits, the teaching physician must be present via interactive telecommunications during the portion of the services that determines the level of services billed.

The medical records must document if the teaching physician was physically present or if the teaching physician was present through interactive telecommunications technology at the time the service is furnished. The presence of the teaching physician during procedures and evaluation and management services may be demonstrated by the notes in the medical records made by the physician attestation statement.

21. *The coding guidance is incorrect! U07.1 and pneumonia code. Not B97.29 anymore*

    The guidance in the presentation and from CMS, AHA and Coding Clinic, is the use of code U07.1 went into effect on April 1, 2020. Prior to that code B97.29 was the correct code. If the patient was discharged on or after April 1, 2020 the correct coding is U07.1 with J12.89 if the documented COVID-related pneumonia is present.

22. *Is Z03.818 appropriately reported as a secondary diagnosis for an inpatient? Guidelines for observation in Chapter 21 states these codes are used for principal or first listed only. Does the new guideline for Chapter 1 allow us to assign Z03.818 as secondary diagnosis for pts with possible exposure ruled out with a negative test?*

    At this time, Z03.818 is only to be assigned as a first-listed/principal diagnosis code and cannot be assigned as a secondary diagnosis.

23. *Slide 27 - Z03 is a principal diagnosis only. Would you assign the other codes secondary then? - Correction: Z03 is a PDX primary diagnosis code*

    Yes, Z03.xx is assigned as primary/principal diagnosis only, so in the case of suspected COVID-19 if patient documented as suspected COVID that was ruled out assign Z03.818 as primary/principal diagnosis. If the patient had exposure to COVID, and their test is negative or unknown, assign Z20.828 as primary/principal diagnosis. If documented as "suspected COVID", you would assign the sign and symptom codes such as R05 Cough, R06.02 Shortness of Breath and/or R50.9 Fever unspecified. The signs and symptoms codes would be assigned as secondary diagnosis codes to a Z03.xx code when appropriate.