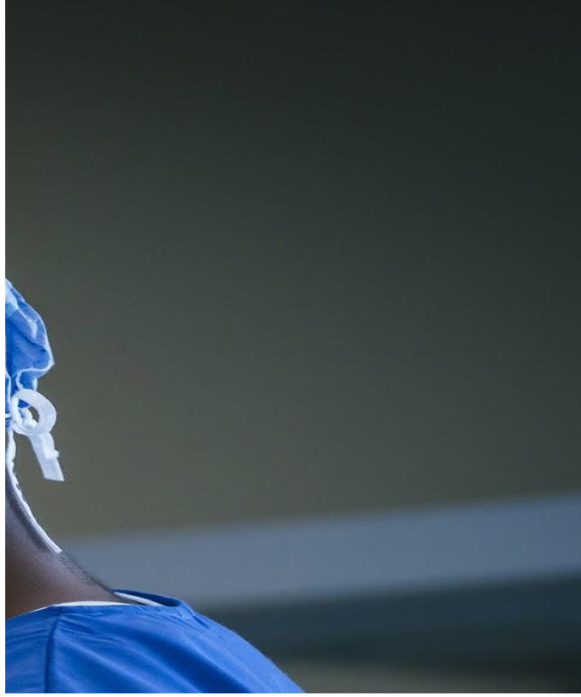
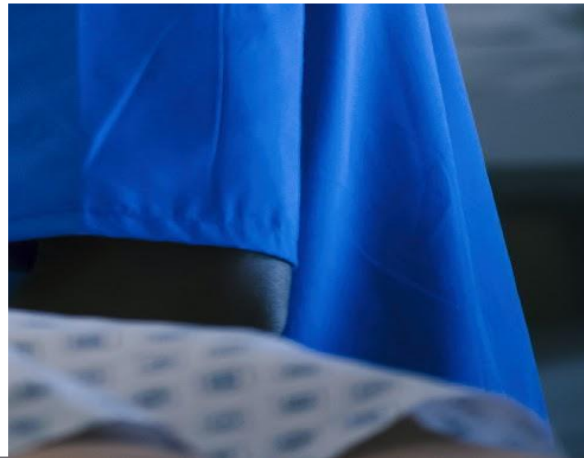


COVID-19

Coding, Billing, Telehealth, and Patient Cost Sharing Relief and Implications

Updated as of April 30, 2020



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COVID-19 Coding, Billing and Telehealth Federal Guidance
Updated: April 30, 2020 1:00PM EST

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Diagnosis Coding

Dates of Service prior to 4/1/2020

ICD-10-CM Official Coding Guidelines[1] have been updated to address diagnoses specifically related to the COVID-19 Coronavirus outbreak including the following conditions when confirmed as due to COVID-19:

- Pneumonia: J12.89 and B97.29
- Acute bronchitis: J20.8 and B97.29
- Bronchitis not otherwise specified (NOS) : J40 and B97.29
- Lower respiratory infection NOS or acute respiratory infection NOS: J22 and B97.29
- Respiratory infection NOS: J98.8 and B97.29
- Acute respiratory distress syndrome (ARDS): J80 and B97.29

Exposure to COVID-19

- Possible exposure to COVID-19 ruled out after evaluation: Z03.818
- Actual exposure to someone who is confirmed to have COVID-19 : Z20.828

Screening for COVID-19 in an asymptomatic patient: Z11.59

Diagnosis code B34.2 would generally not be appropriate for COVID-19 and B97.29 should not be used if the provider documents "suspected", "possible" or "probable" COVID-19

Dates of Service on or after 4/1/2020

The Centers for Disease Control and Prevention (CDC) announced March 18, 2020 that a new ICD-10-CM code for COVID-19 will be implemented for use starting April 1, 2020[2]. The CDC plans to issue additional guidance by March 20, 2020. The new code is listed below along with the related ICD-10-CM instructional notes:

- U07.1 COVID-19
  Use additional code to identify pneumonia or other manifestations
  Excludes1: Coronavirus infection, unspecified site (B34.2)
  Coronavirus as the cause of diseases classified to other chapters (B97.2-)
  Severe acute respiratory syndrome (SARS), unspecified (J12.81)

Telehealth on subsequent pages

Procedural Coding

Providers conducting COVID-19 diagnostic testing will have to wait until after April 1, 2020 to submit a claim to Medicare for the testing services using codes U0001 and U0002 for dates of service on or after February 4, 2020.[3]

No unique codes for evaluation and management (E/M) services / procedures related to COVID-19 currently exist. Providers should, however, document time spent with the family or time spent coordinating any COVID-19 related care that is not face-to-face with the patient and/or family.

As of March 16, 2020, the American Medical Association (AMA) created a new CPT code[4] to describe laboratory testing for the novel coronavirus. However, it is unclear yet if this code will be recognized and priced by Medicare or how quickly the other payers may adopt its use.

- 87635 Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique

This code comes just weeks after the Centers for Medicare and Medicaid Services (CMS) issued two new HCPCS codes for these laboratory testing services.

- U0001 CDC 2019 Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel
- U0002 Non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19)

As of April 10, 2020, AMA created two new CPT codes to for reporting antibody testing for the novel coronavirus and revised one CPT code[29] for SARS-CoV-2 nucleic acid tests.

- 86318 Immunoassay for infectious agent antibody(ies), qualitative or semiqualitative, single step method (eg, reagent strip);
- 86328 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])

These codes are effective for use immediately (for services provided on or after April 10, 2020).

April 14, 2020, CMS announced the creation of two additional codes for COVID-19 diagnostic testing that utilizes high throughput technology.* The following codes are effective for dates of service on or after March 18, 2020:

- U0003 **Equivalent to 87635 only high throughput** Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies
- U0004 **Equivalent to U0002 only high throughput** 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies

Codes U0003 and U0004 are not used to detect COVID-19 antibodies.

*High throughput technology uses a platform that employs automated processing of more than 200 specimens a day – Examples include:

- Roche cobas 6800 System
- Roche cobas 8800 System
- Abbott m2000 System
- Hologic Panther Fusion System
- GeneXpert Infinity System
- NeuMoDx 288 Molecular

Providers and health care organizations should reach out to their payers to determine specific reporting guidelines for these codes.

Reimbursement

No beneficiary cost-sharing under Original Medicare for COVID testing (see "Billing" section for information on cost-sharing waiver reporting.

Local Medicare Administrative Contractors (MACs) are responsible for developing the payment amounts for claims they receive for these newly created HCPCS codes (U0001-U0003) in each jurisdiction until Medicare establishes national payment rates.[5]

Medicare Advantage (MA) plans may waive or reduce enrollee cost-sharing for COVID-19 laboratory tests for all plan enrollees on a uniform basis.[6]

Federal COVID-19 Guidance (continued)

Billing

Billing requirements for indicating payment is based on "formal waiver"[7]:

- **Institutional claims** (UB-04 or 837i):
  Condition code "DR" (disaster related)
  Reported at the claim level when all of the services / items billed on the claim are related to a COVID-19 waiver
- **Part B billing**, both institutional and non-institutional including pharmacies (CMS-1500 or 837p and NCPDP):
  Modifier "CR" (catastrophe / disaster related)
  Identifies line item services related to a COVID-19 waiver

Temporary expansion sites during the PHE[25]:

- ✔ Need to meet the refined hospital conditions of participation
- ✔ Follow existing rules to bill under the applicable Medicare payment system depending on whether outpatient care or inpatient care was provided
- ✔ Indicate the services provided were based on a "formal waiver" by:
  - Hospitals: add condition code "DR" to inpatient or outpatient claims
  - Practitioners: report the applicable place of service code and append modifier "CR" to professional claims

Note: Telehealth claims do not require the "DR" condition code or "CR" modifier for Medicare payment.[8]

Waived Cost-Sharing[23]: For dates of service on or after March 18, 2020, cost-sharing of Medicare Part B coinsurance and deductibles have been waived for COVID-19 testing-related services. Specifically, cost-sharing is waived for the following:

- Encounters where COVID-19 lab tests (U0001, U0002, 87635) are ordered or administered OR
- Evaluations of a patient to determine if COVID-19 testing is needed

Modifier "CS" should be appended to the Part B claim line items for the above services when reported with any of the following HCPCS categories for payments to the following providers / suppliers:

HCPCS Category

- Office/Other outpatient services
- Hospital observation services
- Emergency department services
- Nursing facility services
- Domiciliary, rest home or custodial care services
- Home services
- Online digital E/M services

Providers / Suppliers

- Hospital outpatient departments paid under the OPPS
- Physicians and other professionals under the physician fee schedule
- Critical access hospitals
- Rural health clinics
- Federally qualified health centers

Uninsured Patients

The Health Resources and Services Administration (HRSA) has provided the following information for claims submission / reimbursement for COVID-related testing and treatment provided to uninsured patients.

As part of the Families First Coronavirus Response Act (FFCRA), Paycheck Protection Program, Health Care Enhancement Act , and Coronavirus Aid, Relief, and Economic Security (CARES) Act, the Department of Health and Human Services (HHS) will provide claims reimbursement to health care providers generally at Medicare rates for testing uninsured individuals for COVID-19 and treating uninsured individuals with a COVID-19 diagnosis."[30]

Beginning May 6, 2020 providers may submit claims for services provided on or after February 4, 2020 to individuals in the U.S. without health care coverage.

Providers who have conducted COVID-19 testing or provided treatment for uninsured COVID-19 individuals may request claims reimbursement electronically and will be reimbursed at Medicare rates, subject to available funding by taking the following steps:

1. Enroll as a participating provider
2. Check patient eligibility
3. Submit patient information
4. Submit claims
5. Receive payment via direct deposit

To participate, providers must attest to the following at registration:

- You have checked for health care coverage eligibility and confirmed that the patient is uninsured. You have verified that the patient does not have coverage such as individual, employee-sponsored, Medicare or Medicaid coverage, and no other payer will reimburse you for COVID-19 testing and/or care for that patient
- You will accept defined program reimbursement as payment in full
- You agree not to balance bill the patient
- You agree to program terms and conditions and may be subject to post-reimbursement audit review

Reimbursement

- Will be based on current year Medicare fee schedule rates except where otherwise noted
- Will be based on date of service
- Publication of new codes and updates to existing codes will be made in accordance with CMS
- For any new code where a CMS published rate does not exist, claims will be held until CMS publishes corresponding reimbursement information

Covered Services

COVID-19 testing and testing-related visits for uninsured individuals as well as treatment for uninsured individuals with a primary diagnosis of COVID-19, including:

- Specimen collection, diagnostic and antibody testing
- Testing-related visits in the following settings:
  - Office
  - Urgent care or emergency room
  - Via telehealth
- Treatment, including:
  - Office visit (including via telehealth)
  - Emergency room
  - Inpatient
  - Outpatient/observation
  - Skilled nursing facility
  - Long-term acute care (LTAC)
  - Acute inpatient rehab
  - Home health
  - Durable medical equipment (DME) (e.g., oxygen, ventilator)
  - Emergency ambulance transportation
  - Non-emergent patient transfers via ambulance
  - FDA approved drugs as they become available for COVID-19 treatment and administered as part of an inpatient stay
- FDA-approved vaccine, when available

Note: For inpatient claims, date of admittance must be on or after February 4, 2020.

Non-Covered Services

- Services not covered by traditional Medicare
- Any treatment without a COVID-19 primary diagnosis, except for pregnancy when the COVID-19 code may be listed as secondary
- Hospice services
- Outpatient prescription drugs

The online portal and additional guidance information / FAQs can be found at: https://coviduninsuredclaim.linkhealth.com/

Federal COVID-19 Laboratory Testing[24]

	Patient / Provider Relationship Required	CPT / HCPCS Level II Code(s) & Guidance	Reimbursement (Based on Medicare Physician Fee Schedule - MPFS)
Specimen Collection For specimens collected to be sent to an outside laboratory. There is no code for swabbing the patient.	New or Established Patients	• 99000 Handling and/or conveyance of specimen for transfer **from the office to a laboratory** • 99001 Handling and/or conveyance of specimen for transfer **from the patient in other than an office to a laboratory** (distance may be indicated) *Blood sample collection* • 36415 Collection of venous blood by venipuncture • 36416 Collection of capillary blood specimen (eg, finger, heel, ear stick) **For use by independent labs**, effective for dates of service on or after 3/1/2020 • G2023 Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)(Coronavirus disease [COVID-19]), any specimen source • G2024 Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)(Coronavirus disease [COVID-19]), **from an individual in a SNF or by a laboratory on behalf of a HHA, any specimen source**	Typically provided in addition to another procedure or service (e.g., E/M service). CMS bundles payment for this service when billed with another procedure / service during the same encounter. 36415: ~$3.00 36416: CMS usually bundles payment for this service when billed with another procedure / service G2023: $23.46 (homebound and non-hospital inpatients) G2024: $25.46 (SNF or on behalf of a HHA)
Laboratory Testing For specimens collected to be sent to an outside laboratory. There is no code for swabbing the patient.	New or Established Patients	Effective for dates of service on or after 3/13/2020 • 87635 Infectious agent detection by nucleic acid (DNA or RNA); COVID-19, amplified probe technique Effective for dates of service on or after 2/4/2020 • U0001 CDC Real Time RT-PCR Diagnostic Test Panel • U0002 Non-CDC laboratory tests for COVID-19 Effective for dates of service on or after 3/18/2020 • U0003 Infectious agent detection by nucleic acid (DNA or RNA); COVID-19, amplified probe technique, making use of high throughput technologies* • U0004 Non-CDC laboratory tests for COVID-19, making use of high throughput technologies* Effective for dates of service on or after 4/10/2020 • 86318 Immunoassay for infectious agent antibody(ies), qualitative or semiqualitative, single step method (eg, reagent strip); • 86328 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])	87635: Not yet priced U0001 $35.91: J6, JK, JJ, JM, JE, JF $35.92: JH, JL, JN, J5, J8, J15 U0002 $51.31: J6, JK, JJ, JM, JE, JF, J5, J8, J15 $51.33: JH, JL, JN U0003 and U0004 $100 86318: 86328: 86769:

For more information on the Emergency Use Authorizations granted by the U.S. Food and Drug Administration (FDA) related to COVID-19 testing, see:
https://www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations#ivdnote1

Additional Federal COVID-19 Related Guidance

Suppliers (DMEPOS): Upgrades for Multi-Function Ventilators[9]

MLN Matters Number: SE20012 informs DME suppliers that effective immediately (4/3/2020), they may provide and bill for multi-function ventilators described by code E0467 as an upgrade where patients only meet the coverage criteria for a ventilator.

A multi-function ventilator (E0467) applies to patients prescribed a ventilator who meet the medical necessity coverage (neuromuscular disease, thoracic restrictive disease, or chronic respiratory failure due to chronic obstructive pulmonary disease) for a ventilator and at least one of the four additional functions (oxygen concentration, cough stimulator, suction pump or nebulizer).

*When the supplier decides to furnish an upgraded DMEPOS item but to charge Medicare and the patient for the non-upgraded item, the supplier must bill for the non-upgraded item rather than the item the supplier actually furnished

Supplier Provides Upgrade And…	ABN Required?	Code(s) & Modifier(s) to Report
Expects no additional payment*	No	E0465-GL **or** E0466-GL Do not report the code for the upgrade
Expects no additional payment however patient requested upgrade	No	E0467-GZ **and** E0465-GK **or** E0466-GK
Expects additional payment from the patient	Yes	E0467-GA **and** E0465-GK **or** E0466-GK

Federal COVID-19 Regulatory Waivers, Interim Rules & Telehealth

Given the current COVID-19 public health emergency[10], the Federal and State Governments have enacted a number waivers with the goal of increasing telehealth coverage to allow patients to be seen without coming into the office/clinic to limit the spread of the illness. The next few pages detail several of the Federal Waivers and the Interim Final Rule that have been issued and the Key Allowances / Modifications each includes.

Through telehealth platforms, Medicare beneficiaries will be able to receive a specific set of services, including:

- Evaluation and Management (E/M) services
- Mental health counselling
- Preventive health screenings

While each of the telehealth services[11] categories has specific billing requirements outlined by Medicare, the waivers and interim final rule grant exceptions, reductions or enforcement discretion for some of the requirements starting with dates of service on or after March 1, 2020. Specifically:

- Patient must initiate the service and give consent to be treated virtually – consent must be documented prior to initiation of treatment
- Expansion of payment is limited as providers must still comply with state telehealth laws and regulations
- Telehealth services may be reported with place of service (POS) 02 or the place of service that would have been used if the patient had come in – note, if POS 02 is used it will be paid at the facility (lower) rate if a service has both a facility and non-facility price
  Modifier 95 should be reported for each claim item provided via telehealth

Additionally, for Telehealth Visits:

- Services will be considered the same as and paid at the same rate as in-person visits

For the latest on state by state updates, see: https://www.cchpca.org/telehealth-policy/current-state-laws-and-reimbursement-policies#

With removal of the originating site and rural requirements, Medicare has expanded coverage for these services in a number of programs where it was not previously allowed (e.g., Federally Qualified Health Centers, Rural Health Clinics, and Programs for All-Inclusive Care of the Elderly - PACE).

Medicare Advantage Plans

According to the April 10, 2020 CMS notice entitled *Applicability of diagnoses from telehealth services for risk adjustment*[27],"Medicare Advantage (MA) organizations and other organizations that submit diagnoses for risk adjusted payment are able to submit diagnoses for risk adjustment that are from telehealth visits when those visits meet all criteria for risk adjustment eligibility…Diagnoses resulting from telehealth services can meet the risk adjustment face-to-face requirement when the services are provided using an interactive audio and video telecommunications system that permits real-time interactive communication…In order to report services to the [Encounter Data System] that have been provided via telehealth, use place of service code "02" for telehealth or use the CPT telehealth modifier "95" with any place of service."

Expanded Use of Ambulance Modifiers[28]

During the PHE, Medicare will cover a medically necessary emergency and non-emergency ground ambulance transportation from any point of origin to a destination that is equipped to treat the condition of the patient consistent with state and local protocols. On an interim basis, the list of destinations may include (but is not limited to):

- Any location that is an alternative site determined to be part of a hospital, critical access hospital or skilled nursing facility
- Community mental health centers
- Federally qualified health centers
- Rural health clinics
- Urgent care facilities
- Ambulatory surgery centers
- Any location furnishing dialysis services outside of an End-Stage Renal Disease (ESRD) facility when an ESRD facility is not available
- Patient's home

Descriptions for the origin/destination modifiers have been expanded to account for the new covered locations:

- Modifier D – Community mental health center, FQHC, RHC, urgent care facility, non-provider-based ASC or freestanding emergency center, location furnishing dialysis services and not affiliated with ESRD facility
- Modifier E – Residential, domiciliary, custodial facility (other than 1819 facility) if the facility is the patient's home
- Modifier H – Alternative care site for hospital, including CAH, provider-based ASC, or freestanding emergency center
- Modifier N – Alternative care site for SNF
- Modifier P – Physician's office
- Modifier R – Patient's home

Federal COVID-19 Regulatory Waivers, Interim Rules & Telehealth (continued)

1135 Waiver & Other Federal Actions (e.g.,DEA)[16]

Key Allowances / Modifications

- ***Licensing***
  "Requirements that physicians or other health care professionals hold licenses in the state in which they provide services if they have an equivalent license from another state"
  Note: CMS has not issued guidance for implementation; "This waiver is for purposes of Medicare, Medicaid, and CHIP reimbursement only – state law governs whether a non-Federal provider is authorized to provide services in the state without state licensure"[12]
- ***HIPAA***
  "Effective immediately, the HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency."[13,14]
- ***Controlled Substances***
  "For as long as the Secretary's designation of a public health emergency remains in effect, DEA-registered practitioners may issue prescriptions for controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met:
  - *The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice*
  - *The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system*
  - *The practitioner is acting in accordance with applicable Federal and State law*[15]

3/17/2020 HR 6074 Telehealth Waiver[17]

Unchanged

- ***Eligible services***
  For a complete list of covered professional services, see https://www.cms.gov/files/zip/covid-19-telehealth-services-phe.zip
- ***Eligible providers***
  Physicians, Nurse practitioners, Physician assistants, Nurse-midwives, Clinical nurse specialists, Certified registered nurse anesthetists, Clinical psychologists (CP), Clinical social workers (CSWs)*, Registered dietitians or nutrition professional*
  Note: CPs and CSWs cannot bill Medicare for psychiatric diagnostic interview examinations with medical services or medical E/M services, including but not limited to CPT codes 90792, 90833, 90836 and 90838.
- ***Modality of delivery***
  Requires live video except for the Hawaii and Alaska telehealth demonstration programs that use store and forward

Key Allowances / Modifications

- ***Location of patient***
  Rural and site requirements have been removed
  Note: Sites not originally allowed pre-COVID-19 may NOT be eligible for the facility fee (Q3014) (e.g., patient home)
- ***Out-of-pocket costs / co-pays***
  Still apply; however, OIG allows providers flexibility to reduce or waive fees.
- ***Prior existing relationship to provide care via telehealth***
  Department of Health and Human Services (HHS) will not conduct audits to ensure prior relationship existed for claims submitted during the Federal State of Emergency

3/26/2020 HR 748 "CARES Act"[18]

Unchanged

- ***Location of patient***
  Rural and site requirements have been removed
  Note: Sites not originally allowed pre-COVID-19 may NOT be eligible for the facility fee (Q3014) (e.g., patient home)
- ***Out-of-pocket costs / co-pays***
  Still apply; however, OIG allows providers flexibility to reduce or waive fees.

Key Allowances / Modifications

- ***Eligible providers***
  Added Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to the list of eligible providers for this emergency period only.
- ***Modality of delivery***
  Removed the language HR 6074 put in requiring phones to have an audio/visual component, allowing phone (audio) only to be a means of delivering services - reported as telephone service
- ***Prior existing relationship to provide care via telehealth***
  Removed the pre-existing relationship clause put in by HR 6074 for services provided via telehealth including remote patient monitoring and virtual check-ins; services may now be provided to both new and established patients

3/30/2020 CMS Interim Final Rule[19] & 4/6/2020 Federal Register[26]

(Effective for DOS on or after 3/1/2020)

Key Allowances / Modifications

- ***Telehealth Place of Service (POS) and Modifier 95***
  Removes the requirement to use POS 02 for telehealth services; allows for reporting the service provided using the POS where it would have otherwise taken place (e.g., office, hospital clinic) but requires modifier 95 to be appended to each service provided via telehealth
- ***Expanding covered telehealth services***
  - *May be provided to patients regardless of location (including home and nursing home)*
  - *Added more than 80 new telehealth services (for use temporarily under the current public health emergency)*
    For a full list, see:
    https://www.cms.gov/files/zip/covid-19-telehealth-services-phe.zip
  - *Allows telehealth to be provided via phone/audio without requiring a video component*
  - *Allows telehealth to be used to fulfil the face-to-face requirement for inpatient rehabilitation facilities, hospice, and home health*
  - *Reduced the requirement to once annually for patient consent as it relates to remote patient monitoring*
  - *Allows telehealth services, remote patient monitoring and virtual check-ins to be provided to both new and established patients*
- ***Office/Outpatient Evaluation and Management (E/M) Services Furnished Via Telehealth***
  Removes any requirements for documenting history and exam and allows providers to report using either:*
  - *Medical decision making (MDM) as currently defined in the 1995 and 1997 guidelines; OR*
  - *The 2021 rules for coding by time (all time associated with the E/M service on the day of the encounter)*
- ***Residents and Teaching Physicians***
  - *Allows residents more flexibility under the direction of the teaching physician*
  - *Teaching physicians may provide supervision using audio/video communication technology*
- ***Allows for wider use of Verbal Orders***
- ***Homebound Status***
  If the physician determines a patient should not leave home because of a medical contraindication or due to suspected or confirmed COVID exposure and the patient needs skilled services, the patient is considered to meet homebound status

**Relevant history and exam should still be documented, as appropriate*

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Federal COVID-19 Telehealth & Technology-Enabled Services

TELEHEALTH SERVICES

	Patient / Provider Relationship	CPT / HCPCS Level II Code(s) & Guidance	Reimbursement (Based on Medicare Physician Fee Schedule - MPFS)
1 Telehealth Visits A visit with a provider that uses telecommunication systems between a provider and a patient.	New or Established Patients	List of provider codes / services: https://www.cms.gov/files/zip/covid-19-telehealth-services-phe.zip • Q3014: Telehealth originating site fee (Facility charge) Not all newly eligible originating sites (under waiver) are eligible for facility fee (e.g. patient home)	Varies, see MPFS: https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx
2 Virtual check-ins A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	New or Established Patients	No geographic or originating site limitations • G2010 (Store & forward) • G2012 (Brief medical discussion) • 99441: Telephone E/M, 5-10 minute medical discussion • 99442: Telephone E/M, 11-21 minute medical discussion • 99443: Telephone E/M, 21-30 minute medical discussion Patient initiated - Not originating from a related E/M service provided within the previous 7 days nor leading to an E/M or procedure within the next 24 hours or soonest available	Varies by geographic locality and facility/non-facility Facility: G2010: $8.85 – $10.39; G2012: $12.49 – $18.05 Non-Facility: G2010: $11.32 – $16.03; G2012: $13.72 – 19.66 99441 – 99443 are not yet priced
3 E-visits A communication between a patient and their provider through an online patient portal.	New or Established Patients	Online digital E/M service • 99421: 5-10 minutes • 99422: 11-20 minutes • 99423: 21 or more minutes Online assessment cumulative time for up to 7 days • G2061: 5-10 minutes • G2062: 11-20 minutes • G2063: 21 or more minutes Were not considered "telehealth" services and were never subject to the telehealth limitations. However, these codes have their own requirements and limitations.	Varies by geographic locality and facility/non-facility Facility: 99421-99423: $12.49 - $58.53; G2061-G2063: $11.68 - $46.54 Non-Facility: 99421-99423: $ 14.34 - $65.79; G2061-G2063: 11.68 - $46.94
4 Interprofessional Telephone/ Internet/EHR Consultations (e-Consults) Provider-to-provider consultations	New or Established Patients	Verbal and written report to treating/requesting provider, time includes medical consultative discussion and review • 99446: 5-10 minutes • 99447: 11-20 minutes • 99448: 21-30 minutes • 99449: 31 minutes or more • 99451: Written report only, 5 minutes or more medical consultative time Cannot be used more than one time in 7 days • 99452: Treating/requesting provider time, 30 minutes	Varies by geographic locality • 99446: $17.20 – $24.91 • 99447: $34.72 – $50.22 • 99448: $51.92 – $75.13 • 99449: $69.28 – $100.20 • 99451: $35.16 – $50.79 • 99452: $35.16 – $50.79
5 Remote monitoring services Includes services such as: • Chronic Care Management • Complex Chronic Care Management • Transitional Care Management • Remote Physiological Monitoring • Principle Care Management	New or Established Patients	• Chronic Care Management (99490 – 99491) • Complex Chronic Care Management (99487 – 99489) • Transitional Care Management (99495 – 99496) • Remote Physiological Monitoring (99457 – 99458) • Principle Care Management (E/M codes) Were not considered "telehealth" services and were never subject to the telehealth limitations. However, each code set has their own requirements and limitations.	Varies by geographic locality and facility/non-facility Facility: 99490–99491: $30.68 - $112.52; 99487–99489: $24.79 – $72.51; 99495–99496: $118.20 - $224.80; 99457–99458: $30.68 - $44.30 Non-Facility: 99490–99491: $38.71 - $112.52; 99487–99489: $83.56 - $116.09; 99495–99496: $171.34 - $316.80; 99457–99458: $38.71 - $65.28

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SPECIFIC PLANS, PROGRAMS AND FACILITY TYPE REGULATIONS

Skilled Nursing Facility (SNF)
The 3-day prior hospitalization requirement has been waived.

For certain beneficiaries who recently exhausted their SNF benefits, the SNF may renew coverage without having to start a new benefit period.

Extends the timeframe requirements for Minimum Data Set (MDS) assessments and transmission[7]

DMEPOS
Waives replacement requirements of face-to-face encounter, new physician order and new medical necessity documentation for DMEPOS that is lost, destroyed, irreparably damaged or otherwise rendered unusable or unavailable.

Suppliers must still included a description on the claim explaining why the equipment needs to be replaced [7]

Medicare Advantage Plans
Step that must be taken in response to COVID-19:
1. Adopt a multi-prong approach to communication
2. Post FAQs on your site
3. Ensure members get appropriate access to care
4. Have a contingency plan in place
5. Work closely with state and local authorities
6. Use of free tools to help with planning and communication [20]

Home Health Agency (HHA)
Extends the timeframe requirements for OASIS transmission.
MACs may extend the auto-cancellation date of Requests for Anticipated Payments (RAPs). [7]

The Interim Final Rule expanded definition of homebound status.[19]

For more information and on-going updates, also see: https://homehealthcarenews.com

Prescription Drug Coverage
Replacement fills for medications that have been lost or are otherwise unusable or unavailable may be issued (up to the amount originally dispensed) and covered Part B. [7]

Allows controlled substances to be prescribed as part of a telehealth visit in lieu of an in-person face-to-face encounter. [21]

State Medicaid Programs
Do have the ability to waive copayments.
- Submit a state plan amendment (SPA) – applied based on the particular item or service received; **OR**
- Request a time-consuming Section 1115 authority to suspend copayments only for individuals who need treatment for COVID-19 infection[22]

Critical Access Hospital (CAH)
Waives the 25 bed and the 96 hour length of stay limitations. [7]

Long-Term Acute Care Hospital (LTCH)
Waives the 25-day average length of stay payment requirement for patient says where patients were admitted or discharged to meet the demands of the COVID-19 emergency. [7]

Ambulance
No waiver of ambulance payment and coverage requirements.

Expanded use of origin and destination modifiers.

Note: In certain circumstances, the waivers granted to institutional providers can indirectly affect payment for ambulance transports[16]

COVID-19 Related State Legislation
https://www.ncsl.org/research/health/state-action-on-coronavirus-covid-19.aspx

For the updated on national guard activations, restricted travel and other state-specific resources and actions: https://www.nga.org/coronavirus/#states

References / Resources

[1]https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf
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[3]https://www.mwe.com/insights/cms-releases-fact-sheets-on-covid-19-medicare-coverage-billing-guidelines/
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[12]https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
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[30] https://www.hrsa.gov/CovidUninsuredClaim

Families First Coronavirus Response Act

Patient Cost Sharing Relief and Implications for Providers

On March 19, 2020 the Senate passed the second phase of legislation to respond to the coronavirus, including important provisions to extend paid sick leave, unemployment insurance, and provide free—no copays, no deductibles—coronavirus testing for all Americans.

SEC. 6001. Coverage of Testing for COVID-19

A group health plan and a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan (as defined in section 1251(e) of the Patient Protection and Affordable Care Act)) shall provide coverage, and shall not impose any cost sharing (including deductibles, copayments, and coinsurance) requirements or prior authorization or other medical management requirements, for the following items and services furnished during any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b–5(g)) beginning on or after the date of the enactment of this Act…

SEC. 6002. Waiving Cost Sharing Under the Medicare Program for Certain Visits Relating to Testing for COVID-19

…such deductible shall not apply with respect to any specified COVID–19 testing-related service described in paragraph (1) of subsection (cc) for which payment may be made under a specified outpatient payment provision described in paragraph (2) of such subsection

Source: https://www.congress.gov/bill/116th-congress/house-bill/6201/text

Families First Coronavirus Response Act

Patient Cost Sharing Relief and Implications for Providers

(continued)

SEC. 6003. COVERAGE OF TESTING FOR COVID–19 AT NO COST SHARING UNDER THE MEDICARE ADVANTAGE PROGRAM

PROHIBITION OF APPLICATION OF CERTAIN REQUIREMENTS FOR COVID–19 TESTING.— In the case of a product or service described in subclause (IV) or (V), respectively, of clause (iv) that is administered or furnished during any portion of the emergency period described in such subclause beginning on or after the date of the enactment of this clause, an MA plan may not impose any prior authorization or other utilization management requirements with respect to the coverage of such a product or service under such plan

SEC. 6004. COVERAGE AT NO COST SHARING OF COVID–19 TESTING UNDER MEDICAID AND CHIP

(a) Medicaid (2) NO COST SHARING — (G) COVID–19 testing-related services for which payment may be made under the State plan…(b) CHIP (3) PROHIBITION OF COST SHARING.—Section 2103(e)(2) of the Social Security Act (42 U.S.C. 1397cc(e)(2)) is amended—(A) in the paragraph header, by inserting ", COVID–19 TESTING," before "OR PREGNANCY-RELATED ASSISTANCE

Source: https://www.congress.gov/bill/116th-congress/house-bill/6201/text

The CARES Act - Reimbursement for Uninsured Coronavirus Patients

"..An unprecedented, disease-specific support of care for individuals to make sure that people get treatment."
Health and Human Services Secretary, Alex Azar

On April 3rd, the White House announced that it would designate part of the $100 billion in emergency spending to reimburse hospitals and health care providers for uncompensated care provided to COVID-19 patients, through the CARES Act. The funds will be distributed through the Public Health and Social Services Emergency Fund, which supports the National Disaster Medical System.

Important points to note include:

- **Providers will be reimbursed at Medicare rates**
- **Providers will be forbidden to balance bill patients**
- **Money will be sent through the same mechanism used for testing**

HHS Secretary Azar stated that the government will have more specifics on how the rest of the $100 billion will go to providers. Further clarification will be forthcoming.

Americans who recently lost their jobs qualify for special enrollment on healthcare exchanges, and may be eligible for Medicaid, depending on the state. States may also relax certain requirements to be eligible for Medicaid and twelve (12) States have opted to reopen their exchanges.

Implementation of these additional payments has not been clarified, but related information is included in the links below:

https://www.wsj.com/articles/trump-administration-plans-to-pay-hospitals-to-treat-uninsured-coronavirus-patients-11585927877?ns=prod/accounts-wsj

https://abcnews.go.com/Politics/white-house-considers-plan-cover-medical-bills-millions/story?id=69951130

https://www.rollcall.com/2020/04/03/government-plans-to-pay-hospitals-for-covid-19-care-for-uninsured/

https://www.hklaw.com/en/insights/publications/2020/03/covid19-funding-and-recovery-opportunities-for-healthcare-providers

https://www.hhs.gov/about/leadership/secretary/speeches/2020-speeches/remarks-white-house-coronavirus-press-briefing-4-03-20.html

https://www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf

COVID-19 Patient Cost Sharing Implications

Federal Government Initiatives

ISSUE	IMPLICATIONS	ACTIONS	REFERENCES
Catastrophic Health Insurers may waive deductibles and other cost sharing, specific to COVID-19 testing and services	Relaxes guidelines for catastrophic health plans and allows for collection from the insurer for amounts typically paid by consumer	Validate with insurer whether cost sharing has been waived at time of patient registration	https://www.cms.gov/CCIIO/Resources/Files/Catastrophic-Coverage-of-COVID-19.pdf
IRS issued guidelines that allow high deductible health plans to waive deductibles and other cost sharing specific to COVID-19 testing services	Relaxes guidelines for HDHPs and allows for collection from the insurer for amounts typically paid by consumer	Validate with insurer whether cost sharing has been waived at time of patient registration	https://www.irs.gov/pub/irs-drop/n-20-15.pdf
Medicare coverage for telehealth services to prevent patients from having to travel to facilities for care (other than COVID-19). Includes OIG flexibility for the hospital to waive cost sharing	Designed to minimize the spread of the virus. Allows reimbursement for Telehealth. Allows hospitals to provide incentives to patients to take advantage of telehealth services without violation of OIG requirements.	Consider waiving cost sharing to incent patients to take advantage of telehealth. Track waived deductibles and coinsurance as a cost that may be reimbursed as part of the Stimulus plan passed by Congress	https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
Federal government provides relaxed rules to obtain CHIP program and Medicaid program Disaster Relief State Plan Amendments	Can include a variety of issues including impacting/waiving cost sharing requirements, allowing for Presumptive eligibility and other measures	Stay in close contact with state organizations to understand / influence SPA language and to remain up to date on changes in these programs impacting patient responsibility	https://www.cms.gov/newsroom/press-releases/trump-administration-releases-covid-19-checklists-and-tools-accelerate-relief-state-medicaid-chip

COVID-19 Patient Cost Sharing Implications

National Payors – Response to the COVID-19 Pandemic

Top National Payor	Coverage Update
Aetna-CVS Health	• Aetna instituted extra benefits related to COVID-19 including: 1) Free telemedicine visits until June 4th; 2) Free COVID-19 testing and doctor visits ($0 copays); 3) Free care package; and 4) Free delivery on CVS Pharmacy® prescriptions • For COVID-19 treatment, Aetna will waive member cost-sharing for inpatient admissions at all in-network and out-of-network facilities (applies to fully insured and Medicare Advantage) • *https://www.aetna.com/individuals-families/member-rights-resources/need-to-know-coronavirus.html*
Blue Cross Blue Shield Association	• BCBSA announced that its network of 36 independent and locally-operated BCBS companies will waive prior authorizations and increase coverage for COVID-19. BCSB will cover medically necessary diagnostic tests at no cost share to the member. Early medication refill limits are waived on 30-day prescription maintenance medications. BCBS will expand access to telehealth and nurse/provider hotlines. • BCBSA's network of BCBS companies will waive cost-sharing for treatment (including inpatient stays) of COVID-19 through May 31, 2020 • *https://www.bcbs.com/press-releases/blue-cross-and-blue-shield-companies-announce-coverage-of-coronavirus-testing* • *https://www.bcbs.com/press-releases/local-blue-cross-and-blue-shield-companies-waive-cost-sharing-covid-19-treatment*
Cigna	• Cigna announced it will: 1) Waive customer cost-sharing related to COVID-19 screening, testing and treatment; 2) Waive customer cost-sharing for telehealth screenings for COVID-19; 3) Make it easier for customers to be treated virtually for routine care; 4) Provide free home delivery of up to 90-day supplies for Rx maintenance medications; and 5) Support customers with a free, COVID-19 risk assessment tool. • *https://static.cigna.com/assets/chcp/resourceLibrary/medicalResourcesList/medicalDoingBusinessWithCigna/medicalDbwcCOVID-19.html*
Humana	• Humana is implementing the following measures: 1) Testing is fully covered; 2) Telemedicine visits for all urgent care needs fully covered; 3) Early prescription refills allowed for the next 30 days; and 4) Member support line available. • All out-of-pocket medical costs related to covered treatment for COVID-19 (including inpatient admissions) will be waived for in and out-of-network providers • *https://www.humana.com/coronavirus/covid19-humana-member-resources* • *https://www.humana.com/provider/coronavirus/covid19-benefits*
Kaiser Permanente	• Members will not have to pay for costs related to COVID-19 screening or testing if referred by a Kaiser Permanente doctor. Telemedicine visits are strongly encouraged, especially for high risk patients. • Kaiser Permanente will eliminate member out-of-pocket costs for COVID-19 treatment (fully insured plans, all lines of business, in all markets) • *https://healthy.kaiserpermanente.org/health-wellness/coronavirus-information* • *https://about.kaiserpermanente.org/our-story/news/our-perspective/costs-waived-for-members-receiving-covid-19-treatment*
United Healthcare	• UHC will waive costs (copays, coinsurance and deductibles) for COVID-19 testing. UHC will expand telehealth services and will allow early prescription refills. UHC is rapidly expanding access to their personalized digital care platform for highest-risk members. For those under home isolation, UHC established a navigation support program, providing patients with a dedicated customer service professional to guide them and provide support. • UHC is waiving member cost-sharing for the treatment of COVID-19 until May 31, 2020 (Medicare Advantage, Medicaid, Individual and Group Market fully insured health plans) • *https://newsroom.uhc.com/news-releases/UnitedHealthcare-COVID-19.html*

COVID-19 Patient Cost Sharing Implications

Operational Considerations

Revenue Cycle Operational Considerations
as
❑ Establish a plan and maintain a consistent approach in addressing patients' prior balance collections
❑ Develop a COVID-19 patient letter outlining billing protocols and collections
❑ Educate front-line staff to communicate to patients the impacts of COVID-19 billing requirements and patient financial obligations
❑ Deploy a 24/7 operational virtual customer service department, if necessary, to support patients and families needs
❑ Develop COVID-19 collection strategies for uninsured and incorporate State waiver and Federal Stimulus details
❑ Consider impacts on Out of Network billing policies/procedures for COVID visits (e.g. billing OON Payers the cash price)
❑ Assign a team member to tracking CMS, Insurance and AMA changes and guidelines
❑ Re-evaluate charity care calculations and adjust the sliding scale used to allow for more people to be eligible for charity care or offer a larger discount if patients pay at the time of service
❑ Update chargemaster for COVID-19 testing and treatment as necessary including telehealth services
❑ Contact your largest in-network commercial payor partners and determine if they are willing to relax requirements on authorization and filing limits for non-COVID cases
❑ Consider impacts on refund policy/procedure for canceled electives as well as standardizing communications for when/how elective procedures will be rescheduled

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