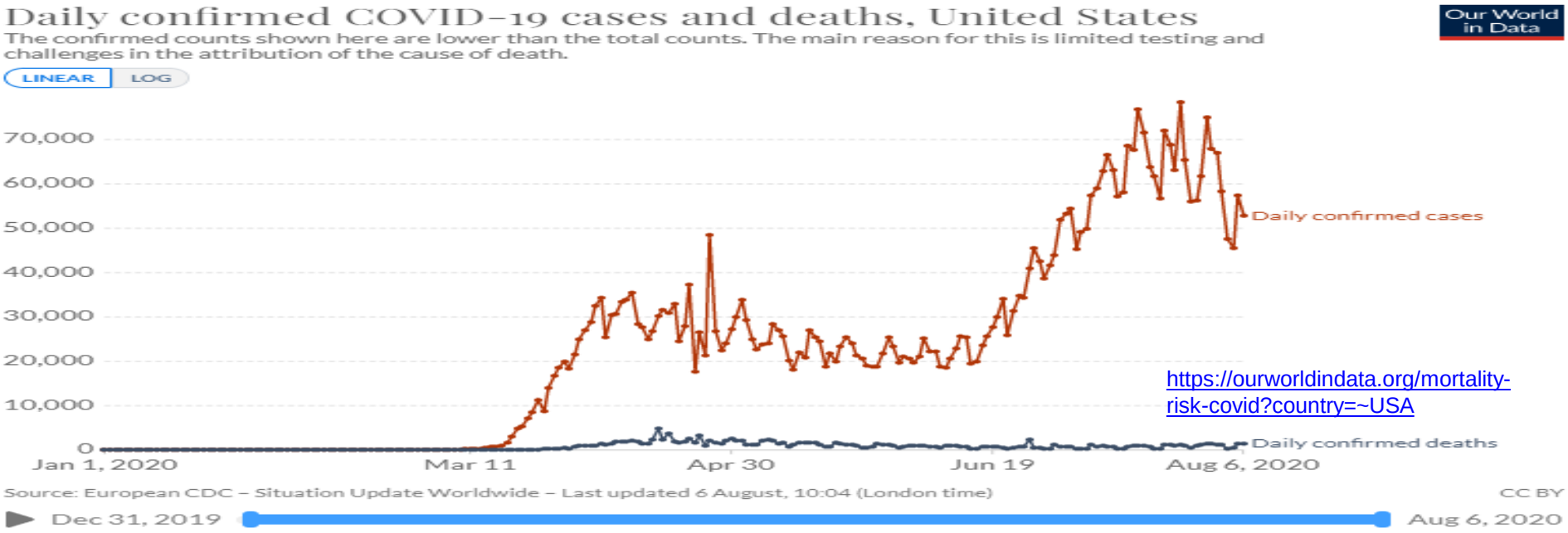

COVID-19 Denial Management

Impact of Coronavirus on Revenue and Reimbursement

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COVID-19 Denial Management

- Initially, the AHA estimated a four-month financial impact of $202.6 billion in losses for America's hospitals and health systems, or an average of $50.7 billion per month
- Crisis has continued much longer than expected and impact has risen on a similar trajectory
- The need to capture reimbursement for all services performed is paramount in these challenging times

COVID-19 Denial Management

- Fast action drives predictable errors
- Medicare, Medicaid and Commercial payors acted quickly to accommodate PHE regulations and the needs of beneficiaries
- Decisions were made and published before MACs received guidance
- Normal processes were circumvented
- Transmittals not available to provide instructions for MAC Outpatient Claim Editors
- CMS Stakeholder calls provided information that was inconsistently interpreted
- Inconsistent retroactive dates for changes

COVID-19 Denial Management

- MACs rely on transmittals and consistent guidance to make changes to automated claims processing processes
- Exactly what they *must* or *may* do
- Which MAC or system is impacted
- What reason code must be returned if exact rules are not satisfied

COVID-19 Denial Management

Number	Requirement	Responsibility							
		A/B MAC			DME	Shared-System Maintainers			
		A	B	HHH	MAC	FISS	MCS	VMS	CWF
10583.1	Contractors shall create a line level reason code to reject any service line(s) that contains a modifier 'GT', except when: • the type of bill is a CAH method II with revenue code 96X, 97X, or 98X; or • the service line contains Healthcare Common Procedure Coding System (HCPCS) code Q3014; or • the type of bill is a CAH method II with revenue code 942 and G0420 or G0421.					X			

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10583.2	Contractors shall reject the line with the following: Group Code CO - Contractual obligation CARC 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 07/01/2017 RARC N519 - Invalid combination of HCPCS modifiers. MSN 16.34 - You should not be billed for this service. You are only responsible for any deductible and coinsurance amounts listed in the 'You May Be Billed' column.	X							

10583.3	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notification, or review them in the MLN Connects weekly newsletter.	X						X	

- MACs accustomed to getting clear guidance from Medicare
- Commercial Payors accustomed to consistent Coordination of Benefits
- Mistakes impacted seemingly unrelated services as well as required changes

COVID-19 Denial Management

- Telehealth Services in Provider Based Settings
- Provider based settings are accustomed to billing a professional and facility component for services performed
- Medicare maintained telehealth services had no facility component since patients were not in facilities
- Medicare created “hospitals without walls” guidance which allowed facilities to consider patient homes part of the facility
- CMS representatives provided inconsistent feedback in Stakeholder calls
  - Q3014 applicable to Telehealth only
  - Consider reprocessing claims if the patient home is listed as a PBD with the RO
- If PBD services are billed as if provider and patient are in the same location, is there an impact on coinsurance?
  - Reimburse Q3014, but do not reimburse G0463
  - Waive cost sharing for telehealth

COVID-19 Denial Management

- No Transmittal to advise MACs how to set up Outpatient Claim Editor (OCE)
- MACs began to return denials based on old transmittals:
  - *HCPCS code Q3014, Telehealth originating site facility fee, is used only when the patient is physically located in your facility. According to the Centers for Medicare & Medicaid Services*
  - *(CMS) Transmittal Number R2095OTN,*
- Some Facilities added modifier GT to the facility component and received denials:
  - *Modifier GT, Via interactive audio and video telecommunication systems, would be appended to HCPCS code Q3014 when Q3014 is billed under CAH Method II on the facility claim form (CMS-1450, UB-04)*
  - *Contractors shall create a line level reason code to reject any service line(s) that contains a modifier 'GT', except when:*
    - *The type of bill is a CAH method II with revenue code 96X, 97X, or 98X; or*
    - *The service line contains Healthcare Common Procedure Coding System (HCPCS) code Q3014; or The type of bill is a CAH method II with revenue code 942 and G0420 or G0421*
  - *Contractors shall reject the line with the following: Group Code CO - Contractual obligation*

COVID-19 Denial Management

- Cannot report G0463 as facility component of telehealth
- Final CMS clarification June 4, 2020: Report Facility Component G0463 if
  - Nurse travels to patient home under “Hospitals without Walls”
  - Provider travels to patient home under “Hospital without Walls”
- Report Q3014 -Originating site fee, for the facility component of a provider-based telehealth visit

COVID-19 Denial Management

- Update to COVID-19 FAQ 7/28/20
- HCPCS code G0463 describes a clinic visit furnished in the hospital outpatient setting when the practitioner and the patient are both located within the hospital. Typically, the hospital would bill G0463 when a professional is located in the hospital and furnishes an evaluation and management outpatient service to a hospital outpatient who is also in the hospital. If a physician is practicing from a hospital that has ***registered the patient as a hospital outpatient in the patient's home, which is serving as a provider-based department of the hospital***, we consider the physician and patient to be "in the hospital" and usual hospital outpatient billing rules would apply in terms of billing for the service(s) furnished. In this situation, there is no distant site practitioner and no telehealth service being furnished.
- Pro bills E/M with no modifier 95
- POS of practice location
- Hospital bills G0463
- This is a clarification, not a change!!!!!!!

COVID-19 Denial Management

COVID-19 Specimen Collection

Independent Lab only

G2023 - Specimen collection Coronavirus disease [COVID-19], any specimen source

G2024 - Specimen collection Coronavirus disease [COVID-19], in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source

March 1, 2020

April 30, 2020

C8903 Hospital outpatient clinic visit specimen collection for Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source

99211- Professional specimen collection for Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source

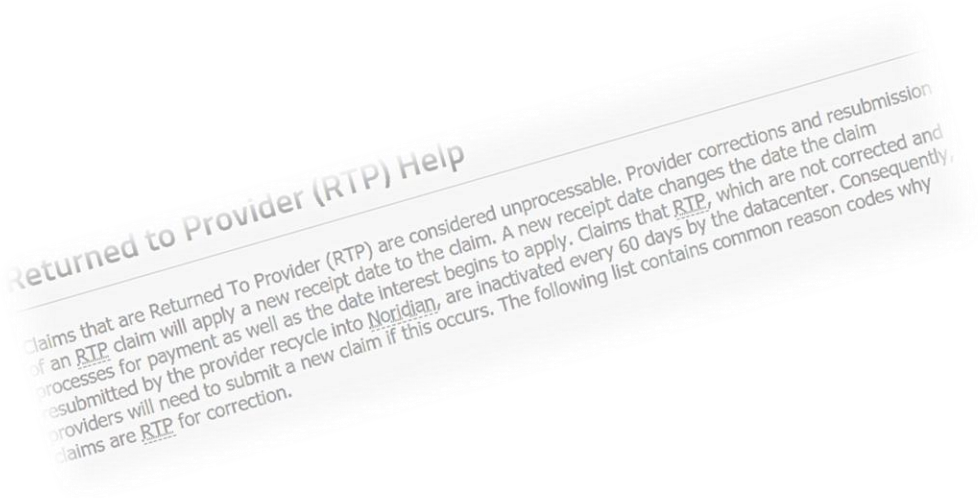
As of April 30 and retroactive, G2023 and G2024 are to be used by independent labs only

COVID-19 Denial Management

- Common specimen processing edits
  - C8903 – OPPS clinic visit specimen collection for Severe Acute Respiratory Syndrome should bundle into Q3014 same day as telehealth
  - 99211 – Professional specimen collection for Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source denying with telehealth visit on the same day
    - Telehealth technically different locations
    - Same POS
  - Some commercial payors requiring Z Codes:
    - Z20.828 – Contact with and suspected exposure to other viral communicable disease in addition to symptoms (R50.9 Fever, R06.02 SOB, R05 Cough) if documented
    - Z11.59 – Encounter for screening for other viral disease
    - Other as applicable

COVID-19 Denial Management

- Some MACS reporting receiving significant number of paper claims containing both POS 11 and POS 02 on the same claim
  - POS 02 for telehealth
  - POS 11 when patient reports to parking lot for specimen collection
- Claims are being returned to provider
- The CMS-1500 form cannot contain more than one POS



COVID-19 Denial Management

- COVID-19 Specimen Processing
- 86375 – Effective March 13, 2020
  - Never accepted by Medicare
- HCPCS implemented April 1 effective February 4
  - U0001 – CDC Lab testing COVID 19 (SARS COV-2)
  - U0002 – Non-CDC lab testing COVID 19 (SARS COV-2)
  - Commercial payors have different effective dates
    - BCBS - Effective for DOS March 13
  - Check effective dates for submission and COB
- April 14, 2020 – High throughput codes
  - U0003: Infectious agent detection (DNA or RNA); (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique
    - Does not specify CDC or non-CDC
    - Alternate CPT code 87635
  - U0004: 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC
    - Corresponds with U0002 if not high throughput technology

COVID-19 Denial Management

- Antibody testing
- Prior to April 10
- 86790-Other viral diseases not elsewhere specified
  - Look for denials or rejections for additional information
- Effective April 10, 2020
  - 86769 - Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])
  - 86328 single step method - 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])
- Effective June 25
  - 87426 – Corona Virus IG IA Qualitative or semi qualitative multi step method
  - Child code under 87301 - Infectious agent antigen detection by immunoassay technique, qualitative or semi quantitative, multiple-step method; adenovirus enteric types
  - Rejecting from MACs
- No retroactive DOS provided
- Check DOS
- Check diagnoses
- Some payors require appropriate Z code

COVID-19 Denial Management

- Commercial denials for testing services
  - Check effective dates by payor
  - Anthem including Medicare Advantage
    - Implemented April 1
    - Retroactive to March 5
    - In effect until May 31
    - Extended most areas but not all systems updated. Expect to appeal
  - United Healthcare
    - Implemented March 30
    - Retroactive to March 18
    - In effect until July 24
    - Check PHE extension
  - Check policy for Z codes
    - Z20.828 - Contact with and (suspected) exposure to other viral communicable diseases
    - Z03.818 – Encounter for observation for suspected exposure to other biological agents ruled out

COVID-19 Denial Management

- G2025 - Telehealth distant site service furnished by a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) only
- Implemented April 30, effective January 27, 2020
- No Transmittal released
- No update to RHC Manual
- MAC crossovers failing
- The claims noted below were not crossed over due to claim errors or were rejected by the supplemental plan." Under each claim is the error description "The procedure code G2025 is not a valid CPT or HCPCS Code for this Date of Service."
- CMS and Benefits Coordination & Recovery Center (BCRC) COBA (middleman) trading partners not recognizing the code.
- CMS pays, then forwards to BCRC
- As recent as July 7, BCRC still documenting this should be fixed by May 27

COVID-19 Denial Management

- CS Modifier - CMS waives cost-sharing (coinsurance and deductible amounts) under Medicare Part B for Medicare patients for “COVID-19 testing-related services”
  - Testing related services later defined as outpatient visit only
  - Medicare already waives cost sharing for diagnostic lab
  - Commercial payor denials
- Must resubmit applicable claims with dates of service on or after 3/18/2020 with the CS modifier to get 100% payment
- Professional Pre-op services
  - CS modifier should not be used when pre-surgery examination services are considered to be part of global surgical period
  - During the COVID-19 PHE, the modifier can be reported with separately reported visit codes that result in an order for or administration of a COVID-19 test, when they are related to furnishing or administering such a test or are for the evaluation of an individual for Updated: 8/7/2020 pg. 11 purposes of determining the need for such a test.
  - Per Stakeholder calls, preop testing for COVID-19 can be considered necessary per protocol
  - FAQ 7/28/20

COVID-19 Denial Management

- Cost Sharing Waiver Modifier
- Denial or underpayment review
  - Do not accept denial or underpayment
  - Some MACs did not implement changes timely. If so, they will need to reprocess everything billed with a CS modifier.
  - Do not reprocess if MACs are automatically reprocessing
    - Add reminder or flag to follow up after MAC project completion
  - Check payor guidelines for effective dates and requirement for Z codes in addition to symptoms/conditions

COVID-19 Denial Management

RHC Telehealth Annual Wellness Visits (AWV)

AWVs Allowed

Cost sharing must be waived

Official guidance released July 24: Append modifier CS

COVID-19 Denial Management

- Secondary payers denying Medicare POS 11 and modifier 95
- POS/Modifier mismatch
- Require POS 02 for telehealth

COVID-19 Denial Management

- CERT Audits
- CMS has suspended Comprehensive Error Rate Testing documentation request letters to or conduct phone calls with providers or suppliers to request medical documentation until further notice
- Data is still be collected
- Suspension does not mean forgiveness of audits during this period

COVID-19 Denial Management

- **Q:** If a patient comes to our facility for symptoms and had COVID-19 testing done but it was negative, do we adjust the remaining balance off after insurance pays?
- **A:** Medicare beneficiaries who get tested for COVID-19 are not required to pay the Part B deductible or any coinsurance for this test, but facilities should be paid in full
  - Clinical diagnostic laboratory tests are covered under traditional Medicare at no cost sharing. Cost sharing also waived for the COVID-19 serology test, since it is considered to be a diagnostic laboratory test
  - A provision in the Families First Coronavirus Response Act also eliminates beneficiary cost sharing for COVID-19 testing-related services, defined as associated physician visit or other outpatient visit (such as hospital observation, E-visit, or emergency department services)
- The law also eliminates cost sharing for Medicare Advantage enrollees for both the COVID-19 test and testing-related services and prohibits the use of prior authorization or other utilization management requirements for these services
- Commercial payors *except self funded plans* also waive cost sharing

COVID-19 Denial Management

- **Q:** If a patient was admitted for COVID-19 symptoms and had testing done but it was negative, do we adjust the remaining balance off after insurance pays?
- **A:** Medicare does not waive cost sharing for conditions not confirmed as COVID-19. Other payor guidelines vary. Neither 1135 Federal waivers nor subsequent Interim Final rules require facilities to waive cost sharing for other conditions.

COVID-19 Denial Management

- **Q:** If a self pay patient tests negative for COVID-19, do we have to adjust the amount off?
- **A:** As part of the FFCRA, PPPHCEA, and CARES Act, the U.S. 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
- https://www.hrsa.gov/CovidUninsuredClaim#:~:text=About%20the%20program,with%20a%20COVID%2D19%20diagnosis

COVID-19 Denial Management

Palmetto Known Issues

Status: Palmetto GBA updated the rate for HCPCS code G0071 - Payment for communication technology-based services for 5 minutes or more of a virtual (nonface-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC), to $24.76, effective for dates of service on or after March 1, 2020, until the PHE ends. We will initiate a mass adjustment for any RHC or FQHC claims processed on or after March 1, 2020, with the previous rate for G0071 within 30 days to reflect the $24.76 rate.

CMS updated certain Medically Unlikely Edits (MUEs) and Procedure-to-Procedure (PTP) edits due to COVID-19 retroactive to January 1, 2020

Palmetto GBA issue updating CMS replacement files

Resolved May 8, 2020. Appeals that relate to MUE or PTP denials will be prioritized for review using the replacement files for claims with dates of service on or after March 6, 2020.

COVID-19 Denial Management

- Palmetto Known Issues
- Based on COVID-19 changes outlined in the Interim Final Rule CMS-5531-IFC, and to bring system editing into alignment with CMS direction, Medicare Administrative Contractors will revise edits to accept CPT code 99211 for new and established patients when provided in non-facility place of service codes: 01, 03, 04, 09, 11, 12, 13, 14, 15, 16, 17, 20, 25, 32, 33, 49, 50, 54, 55, 57, 58, 60, 62, 65, 71, 72, 81 and 99.
- Updated 6/15/20
  - Within 30 business days, Palmetto GBA will begin reprocessing any claims with dates of service on or after March 1, 2020, for CPT code 99211 that were denied due to place of service editing during the public health emergency and as noted in the IFC.

COVID-19 Denial Management

- Palmetto Known Issues
- Audio-Only Telephone Evaluation and Management (E/M) Visits
- May 8, 2020, CMS instructed Medicare Administrative Contractors to make the necessary updates to system editing and pricing and to adjust claims affected by each of these updates within 30 days
  - CPT 99441-99443 are now covered services;
  - Medicare Physician Fee Schedule amounts for CPT 99441-99443 have increased; and
  - CPT 99441-99443 are considered primary codes for add-on codes 90785, 90792, 90833, 90836, 90838, 96160, 96161, 99354, 99355, 99358, 99359 and G0506.
- As of May 15, deadline for reprocessing extended 60 days

COVID-19 Denial Management

- Palmetto Known Issues
- Repetitive, Scheduled Non-Emergent Ambulance Transport Prior Authorization
  - Due to COVID-19 related pause in the repetitive scheduled non-emergent ambulance transport (RSNAT) prior authorization model, claims for RSNAT transports submitted on or after March 29, 2020 and before the end of the PHE for the COVID-19 pandemic, should not reject if a provisional affirmative prior authorization (PA) decision period ends and a new Prior Authorization request is not submitted. Currently, system driven editing is rejecting these services.
  - Editing updates have been completed. Claim adjustments will begin in the next few weeks (as of June 4) and this issue will be updated when all adjustments completed

COVID-19 Denial Management

- Palmetto Known Issues
- June 23, 2020
- Outpatient claims with DOS on or after 1/1/2020 are hitting Reason Code 37160 in error. At this time, payments are on hold until correct reimbursements can be made using the FY 2020 wage index.
  - OP Provider Specific Wage Index is missing, or an invalid County Code or Payment CBSA code is present - Processing discontinued. Contact your Audit Reimbursement department
- There is no resolution to this problem at this time. CMS is aware of the issue and is working to resolve.

COVID-19 Denial Management

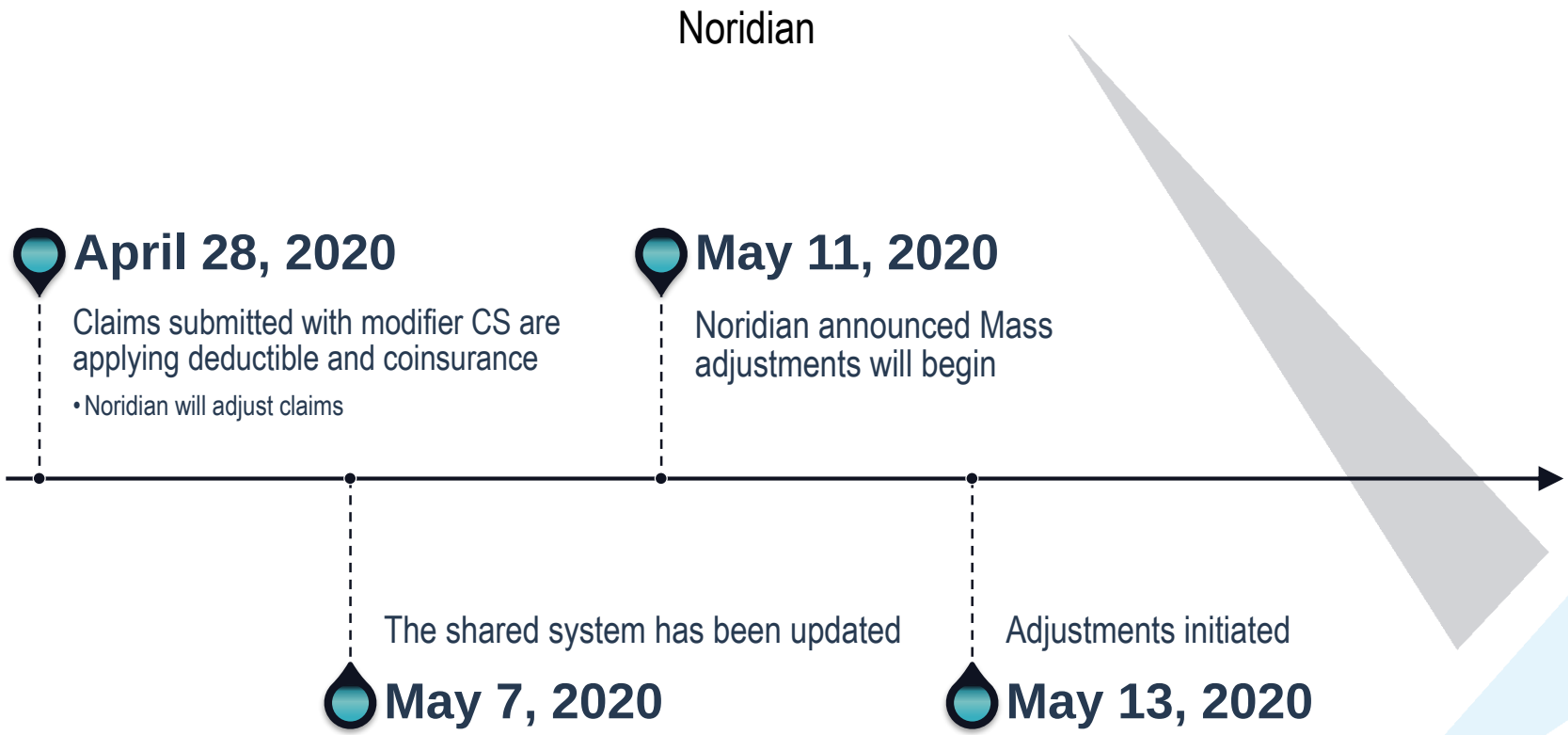
- Palmetto Known Issues
- July 10, 2020
  - Claims are being sent to RTP incorrectly with reason code 37578. This issue is currently being researched.
  - THE SERVICE LINE CONTAINS A LINE LEVEL RENDERING PHYSICIAN NPI NUMBER BUT THE FIRST DIGIT OF THE NPI NUMBER IS NOT EQUAL TO '1' OR THE 10TH DIGIT OF THE NPI NUMBER DOES NOT FOLLOW THE CHECK DIGIT VALIDATION ROUTINE
- Until the issue is resolved, providers can go back into their claims and rekey the NPI information and F9 the claim back in. The claim should process. There is no need for providers to contact the provider contact center (PCC) regarding this matte

COVID-19 Denial Management

WPS Issues

Date Issue Reported	Provider Type Impacted	Description/Claims Coding Impact	Proposed Resolution/Fix/ Action Required	Status	Last Updated
05/28/2020	Speech Language Pathologists, Physical Therapists, and Occupational Therapists	G2061, G2062, and G2063 not allowed for specialty 15, 65, and 67 providers.	Updated June 4, 2020, to allow G2061, G2062, and G2063. We will complete adjustments on claims denied in error.	Open	06/04/2020
06/02/2020	All	COVID-19 codes G2023, G2024, U0001, U0002, and 87635 were not allowed for dates of service prior to April 1, 2020.	Updated June 4, 2020, to correct the issue. We will complete adjustments on claims denied in error.	Open	06/04/2020
04/20/2020	Optometrists	G2010, G2012, 99441, 99442, and 99443 are not allowed by provider specialty 41 providers.	Updated April 28, 2020, to allow procedure codes G2010, G2012, and 99441-99443 by specialty 41 providers. Adjustments will be completed on any claims denied in error.	Open	04/30/2020
04/17/2020	Specialties: Psychologist (Billing Independently, Clinical Psychologist, Licensed Clinical Social Workers	98966, 98967, and 98968 are not allowed by provider specialties 62, 68, and 80 providers.	Updated April 27, 2020, to allow procedure codes 98966-98968 by specialty 62, 68, and 80 providers. Adjustments will be completed on any claims denied in error.	Open	04/28/2020
04/08/2020	All	J5 claims and J8 (Michigan only) place of service 02 for the COVID-19 pandemic were denying. We updated the edit on April 8, 2020.	Updated April 8, 2020, to bypass the edit if the place of service billed was 02. Adjustments have been initiated on the affected claims.	Open	04/17/2020

COVID-19 Denial Management



COVID-19 Denial Management

Novitas

Date Reported	Provider Type Impacted	Workload Impacted	Reason Code	Description/Claim Coding Impact	Proposed Resolution / Fix /Action Required	Status
6/18/2020	Inpatient Periodic Interim Payment (PIP) providers	Inpatient PIP adjustments and cancels	N/A	PIP providers. The claims are suspended to status location SM95HG and cannot be processed to finalization.	CMS is working with FISS and HIGLAS on developing a solution to correct the issue.	Open
3/2/2020	Outpatient	Outpatient therapy services	W7020	HCPCS pairs billed with modifier GN, GO or GP, DOS or after January 1, 2020, are incorrectly denying: 97150 or 97530 with Evals	CMS will be correcting National Correct Coding Initiative (NCCI)	Open

COVID-19 Denial Management

First Coast Options

January 26-February 16: SNF claims incorrectly canceled

A software issue caused skilled nursing facility (SNF) claims to be incorrectly canceled with a message that there was no three-day qualifying hospital stay

Rebill them in sequential order to receive payment.

COVID-19 Denial Management

- Trend denials and rejections
- Check payor websites for known issues
- Do not resubmit unless guidance indicates resubmission required
- Resubmissions will result in duplicate claims, rework and potential overpayments

COVID-19 Denial Management

- Check Dates of service compared to policies for all denials and rejections
- Remember COB partners may have different effective dates
- Check all modifiers and dates of service
  - May need multiple modifiers
  - Telehealth Professional
  - 95 or GT and CS, CR
  - Telephone requires 95,GT after April 30
- Check Payor COVID-19 pages
- Do not accept any denials without secondary review until trends are confirmed

COVID-19 Denial Management

- Create reports
- Review all balance after primary insurance
  - All professional outpatient visit codes
  - G0463
  - Q3014
  - All COVID-19 Lab tests
    - CMS March 18 or later to end of PHE
    - Other payors – check effective dates
- Review all CO45 adjustment codes related to COVID-19 diagnoses
  - U07.1 – COVID-19
  - B97.29 – Other coronavirus as the cause of diseases classified elsewhere
  - Z20.828 – Contact with and (suspected) exposure to other viral communicable diseases
  - Z03.818 – Encounter for observation for suspected exposure to other biological agents ruled out
  - Identify trends then limit review to issues not identified and being reprocessed by payors
  - Set reminders to review denials after payors complete reprocessing

Questions?

Contact

Uniquely Qualified

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Resources

- CDC Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19) https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html
- Palmetto GBA Denial Resolution https://www.palmettogba.com/palmetto/providers.nsf/docsr/Providers~JJ%20Part%20B~Browse%20by%20Topic~Appeals
- CDC: Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19) https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html
- Public Health News Alert: CMS Develops New Code for Coronavirus Lab Test https://www.cms.gov/newsroom/press-releases/public-health-news-alert-cms-develops-new-code-coronavirus-lab-test
- Health Insurance Providers Respond to Coronavirus (COVID-19) https://www.ahip.org/health-insurance-providers-respond-to-coronavirus-covid-19/
- CMS Releases Updated Guidance On EMTALA Requirements And Covid-19 Implications https://www.mwe.com/insights/cms-releases-updated-guidance-on-emtala-requirements-and-covid-19-implications/
- CMS Medicare Claims Processing Manual https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1026cp.pdf
- AMA New CPT code for COVID-19 testing: What you should know https://www.ama-assn.org/delivering-care/public-health/new-cpt-code-covid-19-testing-what-you-should-know

Resources

- HRSA Coronavirus FAQ https://bphc.hrsa.gov/emergency-response/coronavirus-frequently-asked-questions.html
- CMS Coronavirus FAQ https://www.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf
- Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19) https://www.cms.gov/files/document/se20011.pdf
- CMS Telemedicine Fact Sheet https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
- Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19 https://www.kff.org/medicaid/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/
- Emergency Response Changes March 30 https://www.cms.gov/newsroom/press-releases/trump-administration-makes-sweeping-regulatory-changes-help-us-healthcare-system-address-covid-19

Resources

- Virtual Medicine for RHCs and FQHCs https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10843.pdf
- Disaster/Emergency-Related Condition Code and Modifier (Not required as of March 2020 for COVID-19 but guidance may change) https://www.cms.gov/Medicare/Medicare-Contracting/ContractorLearningResources/Downloads/JA6451.pdf
- CMS COVID-19 Toolkit https://www.cms.gov/outreach-education/partner-resources/coronavirus-covid-19-partner-toolkit
- CERT information for providers https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/InformationforProviders

Resources

- Individual payor websites
  - UHC https://www.uhcprovider.com/en/resource-library/news/Novel-Coronavirus-COVID-19.html
  - Aetna https:/www.aetna.com/health-care-professionals/provider-education-manuals/covid-faq.html#acc_link_content_section_responsivegrid_copy__responsivegrid_accordion_
  - Humana https://www.humana.com/provider/coronavirus

https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-07-mlnc-se#_Toc37139913

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