COVID-19 Impact on Revenue Cycle Management

COVID-19 Coding and Billing

- COVID-19 guidance evolved rapidly
- Traditional notification and implementation periods bypassed
- Interpretations and guidance unreliable
- Check for CMS FAQs for current interpretation
- State updates
- Commercial

COVID-19 Coding and Billing

- Medicaid Billing
- Each state has specific authority to modify Medicaid guidance during the Public Health Emergency
  - Authority of the Governor outlines the changes that can be made without federal approval
  - 1135 Waivers – Must request changes from the federal government via an application process with specific options available
  - Appendix K Waivers - Similar process to 135 waivers
    - Some options overlap with 1135
    - Requires federal approval
- WV current 1135 waiver https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/federal-disaster-resources/99171
- WV current Appendix K waivers: https://www.medicaid.gov/state-resource-center/downloads/wv-combined-appendix-k-appvl.pdf

COVID-19 Coding and Billing

- Medicare waived coinsurance for certain outpatient services if the service was provided to order, administer or determine the need for COVID-19 test
  - Office and other outpatient services
  - Hospital emergency department and observation services
  - Nursing facility, domiciliary, rest home, or custodial care services
  - Home services
  - Online digital evaluation and management services
  - Tests necessary to diagnose respiratory illness originally included in verbal interpretation
- Applicable locations:
  - Hospital Outpatient Departments paid under the Outpatient Prospective Payment System
  - Physicians and other professionals under the Physician Fee Schedule
  - Critical Access Hospitals (CAHs)
  - Rural Health Clinics (RHCs)
  - Federally Qualified Health Centers (FQHCs)
- Append Modifier CS (Cost Charing Waived)
- Append condition code DR- Disaster Related, for hospital services
- Append Modifier CR- Catastrophe related for 1500s (professional claim forms)

COVID-19 Coding and Billing

- Append Modifier CS (Cost Charing Waived)
- Append condition code DR - Disaster Related, for hospital services
- Append Modifier CR - Catastrophe related for 1500s (professional claim forms)

COVID-19 Coding and Billing

- Original Language in the Interim Final Rule dated April 28

Finally, section 6002(a) of the Families First Coronavirus Response Act (Pub. L. 116-127) amended section 1833 of the Act by adding a new paragraph (DD) to section (a)(1) and a new paragraph (11) to section (b) to provide, respectively, that the payment amount for a specified COVID-19 testing-related service for which payment may be made under certain CMS-5531-IFC 191 outpatient payment provisions will be

100 percent of the payment amount otherwise recognized and that the deductible for such a service will not apply.

These amendments mean that there is no beneficiary cost-sharing (coinsurance and deductible amounts) for COVID-19 testing-related services, which is defined in new section 1833(cc) of the Act as, among other requirements, are medical visits in any of several categories of HCPCS E/M service codes,

including office and other outpatient services,

that results in an order for or administration of a COVID-19 clinical diagnostic laboratory test described in section 1852(a)(1)(B)(iv)(IV) of the Act and relates to the furnishing or administration of such test

or to the evaluation of such individual for purposes of determining the need of such individual for such test.

COVID-19 Coding and Billing

- FAQ updated 7/24/20:

FAQ27:…The CS modifier should be applied for **certain evaluation and management** services related to COVID-19 testing, whether they are furnished in person or via telehealth. These services are medical visits under the HCPCS evaluation and management categories described below when outpatient providers, physicians, or other providers and suppliers who **bill Medicare for Part B services orders or administers a COVID-19 lab test**, regardless of the HCPCS codes they use to report the test

… For services furnished on or after 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 waiver for COVID-19 testing-related services and should NOT charge Medicare patients any co-insurance and/or deductible amounts for those services.

Additionally, the CPT telehealth modifier, modifier 95, should be applied to claim lines that describe services furnished via telehealth. And the billing practitioner should report the POS code that reflects the place the service would have been furnished if furnished in person.

Update: 7/24/2020

COVID-19 Coding and Billing

- FAQ updated 4/23/20
- Modifier CR and Condition Code DR not required for Telehealth per FAQ updated 5/27/20
- The CR modifier is used by both institutional and non-institutional providers to identify Part B line item services/items that are related to a COVID-19 waiver. Medicare will not deny claims due to the presence of this condition code or modifier for services/items not related to a COVID-19 waiver.

COVID-19 Coding and Billing

- Outpatient Hospital facility Fees
- A hospital may relocate off campus PBD to the patient home by submitting single request per location to the Regional Office, within 120 days of beginning to furnish and bill for services at the relocated on- or off-campus PBD
- Per Interim Final Rule released April 28:
  - “When a registered outpatient of the hospital is receiving a **telehealth service**, the **hospital may bill the originating site facility fee** to support such telehealth services furnished by a physician or practitioner who ordinarily practices there.”
  - **…This includes patients who are at home, *when the home is made provider-based to the hospital*** *(which means that all applicable conditions of participation, to the CMS-5531-IFC 57 extent not waived, are met)”*
- FAQ 7/28/20: *“For hospital outpatient department services that do not involve a distant site provider, but are furnished in an off-campus PBD,* ***hospitals should bill for furnished services on the UB-04 as though the care was furnished in the hospital”***

COVID-19 Coding and Billing

- Specimen collection
  - 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
  - Always intended to be Independent Lab only
  - C9803- Hospital outpatient clinic visit specimen collection for Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]
  - Physician offices can use CPT code 99211 when office clinical staff furnish assessment of symptoms and specimen collection incident to the billing professional's services for both new and established patients
    - When the specimen collection is performed as part of another service or procedure, such as a higher level visit furnished by the billing practitioner, that higher level visit code should be billed and the specimen collection would not be separately payable.

COVID-19 Coding and Billing

- COVID-19 Specimen Processing
- 86375 – Effective March 13, 2020 - rejecting from MACs - Use HCPCS for CMS
- HCPCS implemented April 1
  - U0001 – CDC Lab testing COVID 19 (SARS COV-2)
  - U0002 – Non-CDC lab testing COVID 19 (SARS COV-2)
  - CMS - Effective for DOS February 4 and after
  - BCBS - Effective for DOS March 13
  - COB is challenging
- High Through-put
  - U0003: Infectious agent detection by nucleic acid (DNA or RNA); (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, high throughput technologies as described by CMS-2020-01-R.
    - 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, high throughput technologies as described by CMS-2020-01-R
    - Corresponds with U0002 if not high throughput technology

TELEHEALTH

COVID-19 Coding and Billing

- Common understanding
  - Interactive technology (face to face internet connection)
  - After April 1, 2020 CMS includes physician and NPP telephone
  - Many commercial payors and Medicaid include telephone, with varying effective dates
  - Modifier 95 required, or GT for CAH Method II
- FAQ 4/9/20
  - If the physician or practitioner furnished the service from a place other than where the beneficiary is located (a "distant site"), they should report those services as telehealth services
  - If the beneficiary and the physician or practitioner furnishing the service are in the same institutional setting but are utilizing telecommunications technology to furnish the service due to exposure risks, the practitioner would not need to report this service as telehealth and should instead report whatever code described the in-person service furnished.

COVID-19 Coding and Billing

- Hospital Without Walls
  - Medicare response to the PHE
  - Patient home can be registered as an outpatient department of the hospital
- Per FAQ published 7/28/20:
  - If patient home is registered as PBD
  - And provider originates the visit while in the office
  - The visit is NOT telehealth
  - Both are considered to be in the same location
    - Bill Pro services with no modifier 95, or GT
    - Bill hospital as if patient was in the office
- What about COB?

COVID-19 Coding and Billing

- Traditionally CMS reported telehealth as HCPCS, not CPTs
- No Exam component
- Effective March 30, 2020 Medicare outpatient telehealth services reported by CPT can be based on MDM or time
  - 2021 time-based guidelines or 2020?

CPT	2020 Practitioner Time face to face (50% counseling)	2021 Total Time
99213	Typically 15 minutes	20-29 minutes
99214	Typically 25 minutes	30-39 minutes
99215	Typically 40 minutes	Greater than 39 minutes

COVID-19 Coding and Billing

- CMS Outpatient Therapy Telehealth Implemented June 2, 2020 effective March 30
  - Outpatient therapy can be reported on institutional claims
    - Append modifier 95 to each line
    - Append DR condition code
  - Hospital – 12X or 13X
  - Skilled Nursing Facility – 22X or 23X
  - Critical Access Hospital – 85X
  - Comprehensive Outpatient Rehabilitation Facility– 75X
  - Outpatient Rehabilitation Facility– 74X
  - Home Health Agency (HHA) – 34X
    - Only if patient is not under a home health plan of care

COVID-19 Coding and Billing

- CMS Hospital based Medical Nutrition Therapy and DSMT can be performed remotely as telehealth.
- Per June 2 CMS Stakeholder call for all outpatient therapy
  - Append modifier 95 if patient's home is not registered with the RO as a PBD
  - Do not report modifier 95 is patient's home is a PBD
  - Condition code DR still required

COVID-19 Coding and Billing

- CMS Partial Hospitalization Programs (PBD and non PBD) can be performed via telehealth
  - Excludes services in conjunction with drug administration
- Behavioral Health and education can be furnished via telehealth (including telephone) by providers and NPPs
  - Therapists, social workers, and clinical psychologists can perform telephone visits only

COVID-19 Coding and Billing

- RHC and FQHC Telehealth for Medicare
- Updated April 30, Implementation January 27, 2020 and through PHE
- RHC can act as the distant site for Telehealth
  - Reimbursed $92.03
- Effective July 1,
  - G2025 only
  - Do not append CG modifier and modifier 95 optional
  - Report telephone professional audio only services as G2025
    - All requirements of audio only telephone CPT codes still apply

COVID-19 Coding and Billing

Telehealth documentation example:

Patient initiated a request for care. I introduced and identified myself, received verbal consent from the patient to proceed with this video and audio communication (or telephone) visit.

I verified the patient's name and date of birth.

Reason for visit: Head strike

36-year-old with persistent headaches after head strike. Episode happened on 3/1/20, patient bent over to pick up a blood pressure cuff and accidentally hit a metal rod. Initial headache was mild.

Past medical – reviewed and not pertinent

Family – Mother-diabetes, hypertension

Assessment/Plan:

Patient symptomology is consistent with post concussive syndrome.

Ibuprofen 600-800 mg with food for more intense headaches

MRI brain without contrast (this can be performed next month after expected peak of pandemic)

Follow-up in 3 months

COVID-19 Coding and Billing

- Telephone visits
  - Added to the Medicare telehealth list for providers and NPPS
  - Modifier GT, 95 required
  - Not considered telehealth for “other providers”
  - CPT rules must be followed
    - Not originating from a related E/M service provided within the previous 7 days
    - Not leading to an E/M service or procedure within the next 24 hours or soonest available appointment
  - Map revenue to 99213-99215
    - 99441: 5-10 minutes of medical discussion
    - 99442: 11-20 minutes of medical discussion
    - 99443: 21-30 minutes of medical discussion

COVID-19 Coding and Billing

- Other provider telephone not added to telehealth, no modifier GT,95
- Same CPT requirements
  - 98966: 5-10 minutes
  - 98967: 11-20 minutes
  - 98968: 21-30 minutes

COVID-19 Coding and Billing

- Online visits – cumulative time over 7 days for the same issue
- Secure HIPAA compliant platform
- Provider, NPP
  - 99421 - 5-10 minutes
  - 99422 - 11-20 minutes
  - 99423 - 21 or more minutes
- Other healthcare professional
  - CPT
    - 98970 - 5-10 minutes
    - 98971 - 11-20 minutes
    - 98972 - 21 or more minutes
  - HCPCS
    - G2061 - 5-10 minutes
    - G2062 - 11-20 minutes
    - G2063 - 21 or more minutes

COVID-19 Coding and Billing

- Brief communication technology- virtual check-in
  - Five- ten minutes medical discussion
  - G2012 – Outpatient
  - G0071 – RHC and FQHC
- Remote patient monitoring
  - Acute or chronic conditions
  - Thirty minutes per 30 days, Medicare reduced to fewer than 16 of thirty days
  - Nurse can review patient data with provider to determine if home treatment is safe/effective
    - 99091: Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted
  - 99457-58: Remote physiologic monitoring, interactive communication with the patient/caregiver during the month; time based
  - 99473-74: Self monitored Blood Pressure (30-day period)
  - 99493-94: Subsequent psychiatric collaborative care management, per month

Coding Updates

COVID-19 Coding and Billing

- Effective 4/1/20
- U07.1 – COVID-19

  Use additional code to identify pneumonia or other manifestations

  EXCLUDES 1 Coronavirus infection, unspecified (B34.2)

  Coronavirus as the cause of diseases classified elsewhere (B97.2-)

  Pneumonia due to SARS-associated coronavirus (J12.81)
- Not intended as a secondary diagnosis

COVID-19 Coding and Billing

Presenting Problem	Negative Test	Positive Test
Asymptomatic*	Z20.828 -Contact with and (suspected) exposure to other viral communicable diseases	U07.1 - COVID-19*
Symptomatic*	Signs & Symptoms Z20.828	U07.1
Pregnant Asymptomatic*	Z34._ _ Encounter for supervision of normal pregnancy (add”first” or “ other” pregnancy, add trimester) Z20.828	O98.51_ Other viral diseases complicating pregnancy (add trimester) U07.1
Pregnant Symptomatic*	O99.89 – Other specified diseases and conditions complicating pregnancy, childbirth and the puerperium Z20.828	O98.51_ U07.1
Pre-procedural	Z01.81_* Encounter for preprocedural examinations (add exam type) Z20.828	U07.1 COVID-19*
Antibody testing	Z01.84 - Encounter for antibody response examination	N/A
Follow-up Exam	Z09 - Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm Z86.19 - Personal history of other infectious and parasitic diseases	U07.1 COVID-19*
Personal HX of	Z86.19	U07.1 COVID-19*

*If COVID-19 positive, code additional confirmed manifestation codes, respiratory codes do not need to be linked to the test results.

COVID-19 Coding and Billing

Presenting Problem	Negative Test	Positive Test
No known exposure Screening	Z11.59 – Encounter for screening for other viral disease	U07.1 COVID-19*
Possible exposure – ruled out	Z03.818 – Encounter for observation for suspected exposure to other biological agents, ruled out	N/A
Known or possible exposure	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	U07.1 COVID-19*
Antibody testing	Z01.84 – Encounter for antibody response if not being performed to confirm a current COVID-19 infection or is being performed as a follow-up test after COVID-19 positive	N/A
Follow-up Exam	Z09 – Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm Z86.19 – Personal history of other infectious and parasitic diseases	U07.1 COVID-19*
Personal HX of	Z86.19 – Personal history of other infectious and parasitic diseases	U07.1 COVID-19*

*If COVID-19 positive, code additional confirmed manifestation codes, respiratory codes do not need to be linked to the test results.

COVID-19 Coding and Billing

- Inpatient coding
  - ICD-10 MS-DRGs Version 37.1 R1 Effective April 1, 2020
  - The ICD-10 MCE Version 37.1 R1 uses edits for the ICD-10 codes reported to validate correct coding on claims for discharges on or after April 1, 2020.
  - The ICD-10 MS-DRG Grouper software package to accommodate this new code, Version 37.1 R1, is effective for discharges on or after April 1, 2020.

COVID-19 Coding and Billing

Diagnosis Code	Description	MDC (Major Diagnostic Category)	Description	MS-DRG
U07.1	COVID-19	04	Diseases & Disorders of the Respiratory System	177 Respiratory infections and inflammations with mcc
				178 Respiratory infections and inflammations with cc
				179 Respiratory infections and inflammations without cc/mcc
		15	Newborns & Other Neonates with Conditions Originating in Perinatal Period	791 Prematurity with major problems
				793 Full term neonate with major problems
		25	Human Immunodeficiency Virus Infections	974 HIV with major related condition with mcc
				975 HIV with major related condition with cc
				976 HIV with major related condition without cc/mcc

Additional U07.1 related DRG's for patient on a mechanical ventilator – 207 & 208
MCC examples: Pneumonia, ARDS, ARF and CHF if exacerbated
Educate provider thru CDI or other means in importance of documenting co-morbidities

COVID-19 Coding and Billing

- Principle Diagnosis
  - When COVID-19 meets the definition of principal diagnosis, code U07.1, COVID-19, should be sequenced first, followed by the appropriate codes for associated manifestations except
    - Obstetrics patients as indicated in Section I.C.15.s for COVID-19 in pregnancy, childbirth and the puerperium
      - During pregnancy, childbirth or the puerperium, a patient admitted (or presenting for a health care encounter) because of COVID-19 should received a principal diagnosis code of O98.5_, Other viral disease complicating pregnancy, childbirth and the puerperium, followed by code U07.1, COVID-19, and the appropriate code for the associated manifestations(s). Codes from Chapter 15 always take sequencing priority
  - COVID-19 infection that progresses to sepsis
    - Official coding guidelines ICD10-CM I.C.1.d Sepsis, Severe Sepsis and Septic
      - If the reason for admission is both sepsis or severe sepsis and a localized infection, such as pneumonia or cellulitis, a code(2) for the underlying systemic infections be assigned first and the code for the localized infections should be assigned as a secondary code.
        - » Viral sepsis – assign A41.89, other specified sepsis
        - » Use U07.1 COVID-19 to identify the causative agent. Use additional codes for severe sepsis, septic shock and link any organ dysfunction documented if applicable.

COVID-19 Coding and Billing

- Discharges Prior to April 1, 2020
- Pneumonia due to novel Corona Virus COVID -19
  - J12.89 – Other Viral Pneumonia *and*
  - B97.29 - Other coronavirus as the cause of diseases classified elsewhere
- Acute Bronchitis confirmed as due to COVID-19
  - J20.8 - Acute bronchitis due to other specified organisms, *and*
  - B97.29 - Other coronavirus as the cause of diseases classified elsewhere
- Bronchitis not specified as acute confirmed as due to COVID - 19
  - J40 - Bronchitis, not specified as acute or chronic, *and*
  - B97.29 - Other coronavirus as the cause of diseases classified elsewhere
- Lower respiratory infection
  - J22 Unspecified acute lower respiratory infection
  - B97.29 - Other coronavirus as the cause of diseases classified elsewhere
- Respiratory infection not otherwise specified
  - J98.8 - Other specified respiratory disorder
  - B97.29 - Other coronavirus as the cause of diseases classified elsewhere
- Acute Respiratory Distress
  - J80 - Acute respiratory distress syndrome
  - B97.29 - Other coronavirus as the cause of diseases classified elsewhere

Questions?

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COVID-19 Coding and Billing

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