Questions and Answers on

Coding and Documenting Amid COVID-19

Document Last Updated on 4/28/2020

Submit Your Question at www.TrustHCS.com/CoronavirusQuestions

www.RevcPlus.com | www.TrustHcs.com | www.Tsystem.com

Question:

Are hospital based (provider based) clinics able to bill for telehealth visits under the waiver, what about hospital based physical therapists (employed by the facility). What if any of these can be submitted on a UB for facility billing instead of pro fee 1500?

Answer:

G2061 – G2063 – Physical therapists, occupational therapists, speech language pathologists, clinical psychologists can provide e-visits and bill utilizing the following codes:

G2061 Qualified Nonphysician Healthcare Professional Online Assessment, Established Patient, Up To 7 Days, 5-10 Minutes

G2062 Qualified Nonphysician Healthcare Professional Online Assessment, Established Patient, Up To 7 Days, 11-20 Minutes

G2063 Qualified Nonphysician Healthcare Professional Assessment, Established Patient, Up To 7 Days, 21 Or More Minutes Billing for Medicare telehealth services is limited to professionals, so reporting on a UB would not be appropriate.

References / Links:

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

Question:

Are physician exams required when CPT codes 99201 - 99205 are reported for telemedicine services?

Answer:

Yes, all elements are required, just as you would expect them to be performed in a traditional office setting. We now have products and technology that providers can use to remotely examine a patient. In addition, providers can perform exams with their own eyes via video conferencing. Do keep in mind that states have their own requirements for what is needed to "establish care" between a patient and a new provider, so please check state regulations before capturing 99201-99205.

References / Links:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf

Question:

Are we using the regular E/M codes for the Telehealth visit codes? I.e. Patient has a regular E/M visit via the phone regarding their allergies with their PCP and we would normally assign 99213. Are we still assigning 99213 and then using the other CPT of G2010 and G2012 instead of just using the telephone non Face-to-Face E/M CPT code 99443? (even though the visit is via phone) (Part 1 of 4)

Answer:

E/M codes can be utilized when appropriate. However, you would capture either an E/M code or the telehealth code, but not both. Provided below is a summary of some of the details and codes related to telehealth.

- CMS expanded telemedicine benefits with the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act. This expansion will allow payment for office, hospital and other visits furnished via telehealth
- Benefit Start Date: March 6, 2020 and will go through the COVID-19 emergency

Medicare beneficiaries can receive services including:

- Evaluation and management (E&M)
- Mental health counseling
- Preventive health screenings

CMS identifies three main types of virtual services which include:

- -- Virtual Check-ins
- -- E-visits
- -- Medicare Telehealth Visits

References / Links:

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

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Answer:

Virtual Check-in – Established Patients ONLY

- Utilizes telephone or other telecommunication, for a brief check in, to decide if an office visit or other service is needed. Remote evaluation of recorded video and/or images submitted by an established patient.
- Patients must verbally consent to receive virtual check-in services
- Medicare coinsurance and deductible would generally apply to these services

G2010 Remote Eval Recorded Video And/or Images Submitted by Established Patient (e.g., Store and Forward)

G2012 Brief Communication Technology-Based Service, Virtual Check-In, By A Physician or Other QHCP

References / Links:

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

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Are we using the regular E/M codes for the Telehealth visit codes? I.e. Patient has a regular E/M visit via the phone regarding their allergies with their PCP and we would normally assign 99213. Are we still assigning 99213 and then using the other CPT of G2010 and G2012 instead of just using the telephone non Face-to-Face E/M CPT code 99443? (even though the visit is via phone) (Part 2 of 4)

Answer:

E-Visits - Established Patients ONLY

- Utilizes communication between provider and patient through an online patient portal
- Patient must generate the initial inquiry and communication can occur over a 7-day period
- Medicare coinsurance and deductible would generally apply to these services

99421 – 99423 – Physician and nurse practitioners can provide e-visits and bill utilizing the following codes:

> **99421** Online Digital E&M Service Established Patient, Up To 7 Days, Cumulative Time During the 7 Days 5-10 Minutes
>
> **99422** Online Digital E&M Service Established patient, Up To 7 Days, Cumulative Time During the 7 Days; 11-20 Minutes
>
> **99423** Online Digital E&M Service Established Patient, Up To 7 Days, Cumulative Time During the 7 Days; 21 or More Minute

References / Links:

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Question:

Are we using the regular E/M codes for the Telehealth visit codes? I.e. Patient has a regular E/M visit via the phone regarding their allergies with their PCP and we would normally assign 99213. Are we still assigning 99213 and then using the other CPT of G2010 and G2012 instead of just using the telephone non Face-to-Face E/M CPT code 99443? (even though the visit is via phone) (Part 3 of 4)

Answer:

G2061 – G2063 – Physical therapists, occupational therapists, speech language pathologists, clinical psychologists can provide e-visits and bill utilizing the following codes:

> **G2061** Qualified Nonphysician Healthcare Professional Online Assessment, Established Patient, Up To 7 Days, 5-10 Min
>
> **G2062** Qualified Nonphysician Healthcare Professional Online Assessment, Established Patient, Up To 7 Days, 11-20 Min
>
> **G2063** Qualified Nonphysician Healthcare Professional Assessment, Established Patient, Up To 7 Days, 21 Or More Minutes

References / Links:

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Question:

Are we using the regular E/M codes for the Telehealth visit codes? I.e. Patient has a regular E/M visit via the phone regarding their allergies with their PCP and we would normally assign 99213. Are we still assigning 99213 and then using the other CPT of G2010 and G2012 instead of just using the telephone non Face-to-Face E/M CPT code 99443? (even though the visit is via phone) (Part 4 of 4)

Answer:

Medicare Telehealth Visits

- Utilizes telecommunication between provider and patient
- These visits are considered the same as in-person visits and will be paid at the same rate as regular, in-person visits
- The OIG is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs
- During the state of emergence can be assigned to new or established patient

NOTE: To the extent of waiver 1135 requires the patient be established, HHS will not conduct audits to determine if a prior relationship existed during this public health emergency.

99201 -99215 Office and Other Outpatient Visits

G0406 Follow-Up IP Consultation, Limited, Physicians Spend 15 Minutes Communicating w Pt Via Telehealth

G0407 Follow-Up IP Consult, Intermediate, Physicians Spend 25 Minutes Communicating w Pt Via Telehealth

G0408 Follow-Up IP Consultation, Complex, Physicians Spend 35 Minutes Communicating w Pt Via Telehealth

G0425 Telehealth Consult, Emergency Depart or Initial IP, 30 Minutes Communicating w Pt Via Telehealth

G0426 Telehealth Consult, Emergency Depart or Initial IP, 50 Minutes Communicating w Pt Via Telehealth

G0427 Telehealth Consult, Emergency Depart or Initial IP, 70+ Minutes Communicating w Pt Via Telehealth

References / Links:

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Question:

Do you have any advice on the CR modifier and how it will be used for these cases. Apparently it will be used in the outpatient setting, but I not sure which HCPCS codes will receive the modifier.

Answer:

An institutional provider would use the "CR" (catastrophic/disaster related) modifier to designate any service line item on the claim that is disaster related. If all of the services on the claim are disaster related, the institutional provider should use the "DR" (disaster related) condition code to indicate the entire claim is disaster related.

However, CMS has stated that the CR modifier will not be required when reporting Telehealth claims for COVID-19 under the 1135 waiver.

References / Links:

https://www.cms.gov/files/document/se20011.pdf

Question:

Has CMS waived the location of the MD/provider from being a credentialed site, to allowing them to provide Telehealth services from their home? (when they are not credentialed to do so as of yet)

Answer:

There are no payment restrictions on distant site practitioners furnishing Medicare telehealth services from their home. The practitioner is required to update their Medicare enrollment with the home location. The practitioner can add their home address to their Medicare enrollment file by reaching out to the Medicare Administrative Contractor in their jurisdiction through the provider enrollment hotline. It would be effective immediately so practitioners could continue providing care without a disruption.

More details about this enrollment requirement can be found at 42 CFR 424.516. If the physician or non-physician practitioner reassigns their benefits to a clinic/group practice, the clinic/group practice is required to update their Medicare enrollment with the individuals' home location. The clinic/group practice can add the individual's home address to their Medicare enrollment file by reaching out to the Medicare Administrative Contractor in their jurisdiction through the provider enrollment hotline.

References / Links:

https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf

Question:

Hoping someone can provide their opinion on coding dxs B34.2 vs. B97.29 to report Coronavirus-not Covid-19. Patient admitted with cellulitis, treated with antibiotics and also provider documented patient was positive for Coronavirus-HKU1. Patient did not have any symptoms or manifestations such as URI, pneumonia, etc. but they were tested, monitored and seen by Infectious Disease provider so coding of the condition is warranted. Provider documented “Coronavirus infection”. We’re questioning which code below should be assigned. Is it B34.2 since there’s no other illness to code or B97.29 for coronavirus as cause of disease classified elsewhere.

Answer:

The correct code in this scenario would be B34.2, Coronavirus infection, unspecified. The lay terms for ICD-10 code B97.29, Other Coronavirus as the cause of diseases classified elsewhere tells us that this code is to be used when "The provider documents a specific coronavirus not represented by another code as the cause of a disease classified elsewhere." This would not be appropriate since the patient has no clinically documented manifestations due to Coronavirus

References / Links:

https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf

Question:

How do we ensure proper documentation, coding, and reimbursement for COVID-19 services? **(Part 1 of 4)**

Answer:

Payers (federal, state, and commercial) related to testing for COVID-19 or SARS-CoV-2

The majority have published their guidelines for easy access.

Testing codes and appropriate ICD-10-CM codes should be assigned based on individual payer guidelines and coding guidelines.

Medicare Part B covers clinical diagnostic laboratory tests, which are medically necessary (when ordered by a doctor or other nonphysician practitioner).

These are not subject to coinsurance or deductibles.

Imaging (e.g., x-rays, CT scans), for treatment of disease (not for asymptomatic patients) is also a covered Part B benefit but is subject to the usual coinsurance (20% of Medicare allowable) and deductible ($198 in 2020), even for treatment of COVID-19.

References / Links:

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/1135-Waivers-At-A-Glance.pdf

Question:

How do we ensure proper documentation, coding, and reimbursement for COVID-19 services?
(Part 2 of 4)

Answer:

Medicare quickly approved two HCPCS codes for providers and laboratories who perform testing for the SARS-CoV-2 virus.

U0001: CDC 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel

U0002: 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), using any technique, multiple types or subtypes (includes all targets)

These codes are to be reported beginning April 1, 2020 for any tests performed AFTER February 4, 2020.

This means you must hold on to the claim and submit it, with the appropriate code, on or after April 1, 2020.

For the time being, Local Medicare Administrative Contractors (MACs) will be responsible for developing a payment amount for these claims until Medicare establishes an official national payment rate.

References / Links:

https://www.cms.gov/newsroom/press-releases/public-health-news-alert-cms-develops-new-code-coronavirus-lab-test

Question:

How do we ensure proper documentation, coding, and reimbursement for COVID-19 services?
(Part 3 of 4)

Answer:

The American Medical Association (AMA) has created a new CPT for providers and laboratories who perform testing for the SARS-CoV-2 virus, which should be reported for beneficiaries of plans that do not follow Medicare reporting guidelines.

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 is effective for reporting March 13, 2020.

For testing performed prior to this date, check the retroactive guidelines for specific payers.

Claims for tests performed for beneficiaries prior to March 13, 2020 would be reported with 87999 "Unlisted microbiology procedure."

Note: Unspecified codes are used to report services that have not been assigned a CPT or HCPCS code.

References / Links:

https://www.ama-assn.org/practice-management/cpt/covid-19-coding-and-guidance

Question:

How do we ensure proper documentation, coding, and reimbursement for COVID-19 services?
(Part 4 of 4)

Answer:

CMS expanded telemedicine benefits with the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act. This expansion will allow payment for office, hospital and other visits furnished via telehealth

Benefit Start Date: March 6, 2020 and will go through the COVID-19 emergency

Medicare beneficiaries can receive services including:

- Evaluation and management (E&M)
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CMS identifies three main types of virtual services which include:

- Virtual Check-ins
- E-visits
- Medicare Telehealth Visits

References / Links:

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/1135-Waivers-At-A-Glance.pdf

Question:

If the MD is providing Telehealth at their personal home location, does that site need to be payer credentialed? would their personal address need to be on the claim form (box 32 -or any other box?) And what POS would be used for their Home location?

Answer:

There are no payment restrictions on distant site practitioners furnishing Medicare telehealth services from their home. The practitioner is required to update their Medicare enrollment with the home location. The practitioner can add their home address to their Medicare enrollment file by reaching out to the Medicare Administrative Contractor in their jurisdiction through the provider enrollment hotline. It would be effective immediately so practitioners could continue providing care without a disruption.

More details about this enrollment requirement can be found at 42 CFR 424.516. If the physician or non-physician practitioner reassigns their benefits to a clinic/group practice, the clinic/group practice is required to update their Medicare enrollment with the individuals' home location. The clinic/group practice can add the individual's home address to their Medicare enrollment file by reaching out to the Medicare Administrative Contractor in their jurisdiction through the provider enrollment hotline.

References / Links:

https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf

Question:

In case where patient is admitted with Sepsis due to Covid-19, which diagnosis will be listed as PDX, U07.1 or A41.89?

Answer:

According to guidance from AHIMA, ICD-10 code U07.1 is a principle diagnosis code. However, ICD-10-CM guidelines tell us that sepsis is present upon admission and the patient has a localized infection (such as pneumonia due to COVID), a code(s) for the underlying systemic infection (A41.89) should be assigned first and the code for the localized infection (e.g.pneumonia due to COVID) should be assigned as a secondry diagnosis.

AHIMA tells us we cannot use U07.1 as a secondary code, but I suspect that will change. At this time our best guidance is to capture U07.1 as primary. We anticipate further guidance from WHO and the CDC before the effective date on April 1, 2020 and will be providing those as resources when available.

References / Links:

https://journal.ahima.org/ahima-and-aha-faq-on-icd-10-cm-coding-for-covid-19/

Question:

Is POS 2 appropriate for Telephone services 99441-99443?

Answer:

POS 2 indicator is Telehealth. This should be addressed with individual payers as to how they would like these charges/CPT codes reported on the claim form. This information tends to change by the minute. Suggestive to ask for book, chapter, and verse to cover billing in these instances.

References / Links:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf

Question:

Now that we have a definitive code to use as of April 1st., shouldn't the providers either wait for results to finalize their documentation or append the record in order for us to code it correctly vs. a symptom?

Answer:

In the supplemental coding guidelines for Coronavirus, the CDC stated that "For patients presenting with any signs/symptoms (such as fever, etc.) and where a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms". You may continue to assign the codes for signs and symptoms or work with your organization to create a policy to hold coding on encounters until labs are resulted, if feasible for billing purposes.

References / Links:

https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf

https://journal.ahima.org/ahima-and-aha-faq-on-icd-10-cm-coding-for-covid-19/

Question:

One of my providers is telling me that for the telehealth visits billed with the E/M codes 99201-99215 we need to use GT modifiers for established telephone visits and the 95 modifier for established video visits. Can you provide insight on this topic?

Answer:

Category 99201-**99215** would the correct code for Medicare telehealth visits as outlined by CMS.

Modifier GT would only be utilized in a critical access hospital. Effective 1/1/17 the place of service code 02 was implemented to eliminate the requirement of this modifier. The POS of 02 certifies that the service meets the telehealth requirements.

Modifier 95 would be appended to visits that utilized synchronous telemedicine service which means the service is rendered in real-time via interactive audio and video telecommunication. This modifier should only be assigned to codes listed in Appendix P which does include 99201-99215. If you are appending this modifier to any other CPT codes you would need to refer to Appendix P.

References / Links:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf

Question:

Patient comes to ER complaining of cough, congestion, fever, malaise, body aches, sore throat, MD states no known exposure to Coronavirus, they test the patient for Covid-19, does not test for flu or strep, no results on discharge. MD final dx is Covid-19 and upper respiratory infection, sends the patient home and told to quarentine. Is it correct to only being assigned codes for the signs and symptoms?

Also, same scenario minus the congestion and final diagnosis of URI, is it correct again to just code the symptoms?

Neither case would get a Z03 or Z20 code as there is no mention of exposure or suspected exposure, correct?

Answer:

In the supplemental coding guidelines for Coronavirus, the CDC stated that "For patients presenting with any signs/symptoms (such as fever, etc.) and where a definitive diagnosis has not been established, assign the appropriate codes(s) for each presenting signs and symptoms." Diagnosis codes for Coronavirus should only be assigned in true confirmed cases.

You may assign signs and symptoms as documented, but I would recommend working with your organization on an internal policy for holding coding until final COVID results are provided. The same applies when the final diagnosis is URI. I would again, recommend a policy to hold coding until the lab is resulted. Since no known exposure was documented, the Z codes would not be applicable.

References / Links:

https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf

https://journal.ahima.org/ahima-and-aha-faq-on-icd-10-cm-coding-for-covid-19/

Question:

Patient presents with Dyspnea and SOB. No known exposures or concern. Covid test was done due to presenting symptom and pt released. Pts final dx was COPD with acute exacerbation. The Covid test was negative.

Most want to code only the COPD with acute exacerbation.

Some feel they still need to add the Z03.818. Can you offer definitive guidance.

Answer:

The final diagnosis would be coded as the COPD with acute exacerbation.

The CDC provided the following information regarding Z03.818: For cases where there is a concern about a possible exposure to COVID-19, but this is ruled out after evaluation, it would be appropriate to assign the code Z03.818, Encounter for observation for suspected exposure to other biological agents ruled out.

Since in the case described above the patient had no known exposure or concern the Z-code would not be necessary. The code description states, "observation for suspected exposure to".

References / Links:

https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf

Question:

Please comment on the ICD-10-CM code of U07.1 that's implementation date was moved from 10/1/20 to 4/1/20.

Answer:

The following information was published by AHA.

ICD-10-CM code U07.1, COVID-19, may be used for discharges/date of service on or after April 1, 2020. For more information on this code, click here. The code was developed by the World Health Organization (WHO) and is intended to be used as principal or first-listed diagnosis. Specific guidelines for usage will be released shortly. For guidance prior to April 1, 2020, please refer to the supplement to the ICD-10-CM Official Guidelines for coding encounters related to the COVID-19 coronavirus outbreak.

When COVID-19 meets the definition of principal or first-listed diagnosis, code U07.1, COVID-19, should be sequenced first, and followed by the appropriate codes for associated manifestations, except in the case of newborns and obstetrics patients.

Code B97.29 is not exclusive to the SARS-CoV-2/2019-nCoV virus responsible for the COVID-19 pandemic. The code does not distinguish the more than 30 varieties of coronaviruses, some of which are responsible for the common cold. Due to the heightened need to uniquely identify COVID-19 until the unique ICD-10-CM code is effective April 1, providers are urged to consider developing facility-specific coding guidelines that limit the assignment of code B97.29 to confirmed COVID-19 cases and preclude the assignment of codes for any other coronaviruses.

References / Links:

https://www.codingclinicadvisor.com/faqs-icd-10-cm-coding-covid-19

https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf

Question:

Regarding behavioral health tele-visits (face-to-face) should we still use the regular behavioral health codes?

Answer:

Use 99442 – 99443 if phone calls are utilized with no video interaction.

The range of codes 99421 – 99423 (E-Visits) would only be assigned if the provider utilizes patient portals for communication between provider and patient.

The other two categories addressed in the CMS guidance were virtual check-in and Medicare telehealth visits. These categories required audio-video interaction. The legislation allows telehealth services to be provided to Medicare beneficiaries by phone, but only if the phone allows for audio-video interaction between the qualified provider and the beneficiary.

Also, this link has good information on the telehealth codes because the information that is being provide by CMS does not include all of these codes. The coder will need to review all the elements of the documentation and determine which code applies to the situation.

References / Links:

https://www.aap.org/en-us/Documents/coding_factsheet_telemedicine.pdf

Question:

Should we be using 99421-99423 along with G2010 or G2012 for telehealth behavioral health visits? Also, do we need to add the 95 modifier or is that not needed since these codes already state that it is a digital service?

Answer:

You should report either 99421-99423 or G2010 or G2012, but not both.

Use 99442 – 99443 if phone calls are utilized with no video interaction.

The range of codes 99421 – 99423 (E-Visits) would only be assigned if the provider utilizes patient portals for communication between provider and patient.

The other two categories addressed in the CMS guidance were virtual check-in and Medicare telehealth visits. These categories required audio-video interaction. The legislation allows telehealth services to be provided to Medicare beneficiaries by phone, but only if the phone allows for audio-video interaction between the qualified provider and the beneficiary.

Also, this link has good information on the telehealth codes because the information that is being provide by CMS does not include all of these codes. The coder will need to review all the elements of the documentation and determine which code applies to the situation.

https://www.aap.org/en-us/Documents/coding_factsheet_telemedicine.pdf

Modifier GT would only be utilized in a critical access hospital. Effective 1/1/17 the place of service code 02 was implemented to eliminate the requirement of this modifier. The POS of 02 certifies that the service meets the telehealth requirements.

Modifier 95 would be appended to visits that utilized synchronous telemedicine service which means the service is rendered in real-time via interactive audio and video telecommunication. This modifier should only be assigned to codes listed in Appendix P which does include 99201-99215. If you are appending this modifier to any other CPT codes you would need to refer to Appendix P.

References / Links:

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Question:

The CDC announced last week the change in effective date of the new diagnosis code U07.1, COVID-19, from 10/01/20 to next Wednesday's date of 04/01/20. There has been much education given on the supplemental code of B97.29; however, there is not much information out yet about U07.1. Can you please expound on this diagnosis code further for us. Main questions would be when to assign it, what is the description, and would we ever code it alongside other conditions or are they included.

Answer:

The following information was published by AHA.

ICD-10-CM code U07.1, COVID-19, may be used for discharges/date of service on or after April 1, 2020. For more information on this code, click here. The code was developed by the World Health Organization (WHO) and is intended to be used as principal or first-listed diagnosis. Specific guidelines for usage will be released shortly. For guidance prior to April 1, 2020, please refer to the supplement to the ICD-10-CM Official Guidelines for coding encounters related to the COVID-19 coronavirus outbreak.

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https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf

Question:

We are CAH hospital do we need to add a modifier to the claim for diabetic Ed for telemedicine? Does the PO2 come over to the UB?

Answer:

Modifier GT would only be utilized in a critical access hospital. Effective 1/1/17 the place of service code 02 was implemented to eliminate the requirement of this modifier. The POS of 02 certifies that the service meets the telehealth requirements and is reported on the HCFA-1500 form. The UB form would not be appropriate, as this is a professional service.

References / Links:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf

Question:

We are currently holding accounts that don't have a COVID-19 final lab result on them. If the lab comes back and it's confirmed negative for COVID-19, would it be appropriate for the coder to not query and only code an appropriate z-code based on the lab?

Answer:

I would recommend reviewing the doucmentation in that case to determine what prompted the provider to test for COVID. DId the patient have symptoms? Did they have exposure or contact with a known positive person? Did they travel recently? The documentation should support the reason and medical necessity for testing. If you do not have documentation, then a query would be appropriate. I would not recommend simply applying a Z code in this scenario.

References / Links:

https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf

https://journal.ahima.org/ahima-and-aha-faq-on-icd-10-cm-coding-for-covid-19/

Question:

We are having some confusion regarding billing of our well visits. What we are doing, when a patient has a well visit scheduled, is calling or video chatting, depending on the parent's preference, to see if they have questions or concerns, and asking our normal feeding/sleeping/developmental questions. There is no physical exam.

Do you know if this can be billed as a well visit (ex 99391) with a GT modifier, or just as a telephone call, with the 99441 code?

Answer:

The question referenced the preventative medicine 99391 which would require a physical exam, and this cannot be performed via telehealth.

A patient that has a scheduled visit for a chronic condition and the provider contacts the patient and provides a refill for chronic condition and this is provided over the phone utilize CPT codes 99441-99443.

CPT codes 99441-99443 would be assigned for telephone evaluation and management services. As you will notice they are time based which means the documentation would need to specify the time spent on the call as well as detail about the conversation.

> **99441** Telephone evaluation and management services by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
>
> **99442** 11 – 20 minutes of medical discussion
>
> **99443** 21 – 30 minutes of medical discussion

References / Links:

2020 Current Procedural Terminology book

Question:

What additional modifiers are needed to report Telehealth services under the 1135 waiver?

Answer:

Per CMS, there are no additional modifiers required to report Telehealth services provided under the waiver.

"Unlike other claims for which Medicare payment is based on a "formal waiver," telehealth claims don't require the "DR" condition code or "CR" modifier. CMS is not requiring additional or different modifiers associated with telehealth services furnished under these waivers"

References / Links:

https://www.cms.gov/files/document/se20011.pdf

Question:

What are commercial payers doing to support the expansion of Telehealth services?

Answer:

We have seen updates from many commercial providers, including Blue Cross Blue Shield, UnitedHealthcare and Cigna. Some are opening Telehealth services to all covered patients, while others are waiving requirements for immunocompromised patients.

We recommend contacting your organizations Network Representative for each Commercial Payer or checking the online provider portals for guidance on commercial plans in your region.

References / Links:

https://www.ama-assn.org/practice-management/digital/ama-quick-guide-telemedicine-practice?utm_source=Selligent&utm_medium=email&utm_term=%25m%25d%25y&utm_content=HS_CM_CPTNEWS_10_AB_032320-Split_3&utm_campaign=HS_PD_CPT_AssistantNewsletter_FINAL&utm_uid=

Question:

What are the billing recommendations for curb side testing?

Answer:

We are currently unaware of any official billing guidance for curbside testing. However, in most scenarios the patient is presenting to the drive-up testing, is then screened for COVID-19 risk factors, including exposure, traveling, etc.. If the patient qualifies for testing and is swabbed then our recommendation is to bill the applicable lab HCPCS/CPT code only.

References / Links:

NA

Question:

What are the provider documentation requirements for telehealth?

Answer:

Documentation requirements for a telehealth service is the same as for a face-to-face encounter. Providers should document any information about the visit, history, review of systems, or other information that is utilized in the medical decision making. The documentation should clearly state that the service was provided through telehealth and the specific type (video, patient portal, etc). Providers should include their location and the patients location as well as any additional individuals and their roles in the telehealth service.

Also, the CPT codebook provides guidelines and code descriptor that has detail related to the specifics of what is needed.

References / Links:

https://www.mgma.com/resources/financial-management/navigating-telehealth-billing-requirements

Question:

What communication platforms are allowed for use in patient/provider communication under the 1135 waiver?

Answer:

Physicians may use any non-public facing remote communication product available to communicate with patients (even if this product is not fully compliant with HIPAA Rules) – examples include:

- Apple FaceTime
- Facebook Messenger video chat
- Google Hangouts video
- Skype

Providers are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications.

Physicians seeking additional privacy protections should provide telehealth remote communication services through vendors who are HIPAA-compliant and will enter into a HIPAA Business Associate Agreement (BAA) in connection with the use of their product. The below list of vendors have indicated they provide HIPAA-compliant platforms (NOTE: OCR has not reviewed these vendors BAAs and is not endorsing the use of or suggesting certification for any of the below products):

- Skype for Business
- Updox
- VSee
- Zoom for Healthcare
- Doxy.me
- Google G Suite Hangouts Meet

References / Links:

https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

Question:

What CPT code and place of service should be used for global post op visit - 99024 over the telephone?

Answer:

If this is a postoperative follow-up within the global (no dollar amount) 99024 should be assigned. Place of service should be 02. No reimbursement is attached to the claim.

If this outside the global then you would code to the appropriate telehealth based on the telecommunication utilized.

References / Links:

2020 Current Procedural Terminology book

Question:

What DRG will the new COVID-19 diagnosis code, U07.1, route to? What signs and symptoms should or should not be coded along with U07.1? Should presumptive positive COVID19 test results be coded as confirmed?

Answer:

U70.1 COVID-19 (MCC)

MDC 04 - DRGs 177, 178, 179

MDC 15 - DRGs 791, 793

MDC 25 - DRGs 974, 975, 976

According to Section I.B.5 of the coding guidelines, "Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification."

Presumptive positive COVID-19 test results should be coded as confirmed. A presumptive positive test result means an individual has tested positive for the virus at a local or state level, but it has not yet been confirmed by the Centers for Disease Control and Prevention (CDC). CDC confirmation of local and state tests for the COVID-19 virus is not longer required.

References / Links:

https://edit.cms.gov/files/document/icd-10-ms-drgs-version-371-r1-effective-april-1-2020-updated-march-23-2020.pdf

Question:

What information is known about the new U07.1 code besides it should be primary if determined to be the reason for admission after study?

Answer:

U70.1 COVID-19 (MCC)

MDC 04 - DRGs 177, 178, 179

MDC 15 - DRGs 791, 793

MDC 25 - DRGs 974, 975, 976

ICD-10-CM code U07.1, COVID-19, may be used for discharges/date of service on or after April 1, 2020. For more information on this code, click here. The code was developed by the World Health Organization (WHO) and is intended to be used as principal or first-listed diagnosis. Specific guidelines for usage will be released shortly. For guidance prior to April 1, 2020, please refer to the supplement to the ICD-10-CM Official Guidelines for coding encounters related to the COVID-19 coronavirus outbreak.

References / Links:

https://edit.cms.gov/files/document/icd-10-ms-drgs-version-371-r1-effective-april-1-2020-updated-march-23-2020.pdf

https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf

Question:

What is HCPCS code Q3014 and when should it be captured?

Answer:

HCPCS code Q3014 is for use to reimburse an originating site when a patient in a rural area, physician shortage area, or basically outside of a place where applicable care would be available. A patient may present to an office of a provider, a hospital, a critical access hospital, a rural health clinic, a federally qualified health center, a hospital based or CAH based renal dialysis center; a skilled nursing facility, or a community mental health center to meet with another provider via telehealth. Payment is then made to the location the patient presented to for use of their site.

> **For example:** A patient presents to a health clinic complaining of reoccurring staphylococcus infection. There is a physician shortage, as the patient resides in a rural area. A clinical staff employee at the originating site escorts the patient to a room where the patient can interact with an infectious disease provider using audiovisual equipment. The provider remotely performs the necessary history, and a clinical staff employee obtains the clinical information, such as vital signs, requested by the provider. If the clinic has the appropriate equipment and personnel, diagnostic tests ordered by the provider are performed onsite. The provider renders a patient assessment and plan to be discussed with the patient. During this new patient encounter, the provider performs and documents a detailed history, an expanded problem-focused exam, and moderate medical decision making. Q3014 is charged by the site the patient physically presented to for the services as an originating site. The provider who remotely saw the patient would bill an E/M or other appropriate telehealth code.

References / Links:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf

Question:

What is the correct place of service (POS) code to use for e-visits (99421-99422, G2061-G2063) and virtual check-ins (G2012, G2010). The codes are not on the 'telehealth' code list from CMS that uses POS 02.

Answer:

A virtual (G2061-G2063) check-in pays professionals for brief (5-10 min) communications that mitigate the need

for an in-person visit, whereas a visit furnished via Medicare telehealth is treated the same as an inperson visit, and can be billed using the code for that service, using place of service 02 to indicate

the service was performed via telehealth. An e-visit is when a beneficiary communicates with their

doctors through online patient portals.

E-visits (99421-99422) are also to be reporting with place of service 02.

References / Links:

https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Question:

What place of service should be reported with Telehealth visits?

Answer:

Telehealth visits are reported with Place of Service (POS) Code 02- Telehealth

References / Links:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf

Question:

Can we bill a facility fee for a Genetics Counselor (employed by the hospital) telemed visit if the GC is performing a synchronous audio/video call with the Genetics Physician and the patient? Can the physician also bill her professional fee also?

Answer:

Billing for Telehealth services is limited to professionals.

The only fee available for use by facilities is for sites who are hosting the patient- meaning the patient comes into the facility to be connected with a provider remotely. In those cases HCPCS Q3014 is billable.

See FAQ number 13 in the document in the "References / Links" section of this answer.

References / Links:

https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

Question:

Do you have any information regarding the CR modifier? Our facility seems to be in a tailspin trying to figure it out.

Answer:

The CR modifier (catastrophe/disaster

related) is used in relation to Part B items and services for both institutional

and non-institutional billing. On August 31, 2009 use of the CR modifier became mandatory for applicable HCPCS codes on any claim in which MC Part B payment is conditioned directly or indirectly on the presence of a formal waiver.

It is important to note that according to the CMS source cited for COVID-19 related Telehealth claims CMS tells us that "Unlike other claims for which Medicare payment is based on a “formal waiver,” telehealth claims don’t require the “DR” condition code or “CR” modifier. CMS is not requiring additional or different modifiers associated with telehealth services furnished under these waivers"

References / Links:

https://www.cms.gov/files/document/se20011.pdf

Question:

98970-98972 in CPT book states service requires documentation and permanent storage (electronic or hard copy) of the encounter. What is a specific example of an eletronic or hard copy with regards to permanent storage?

Answer:

Example would be documentation of the review, discussion, and/or communication with the patient either on paper in their physcial chart (hard copy) or within the patients Electronic Medical Record (EMR).

References / Links:

NA

Question:

How are telehealth services patient originated from home coded?

Answer:

These visits shall be coded with an appropriate Telemedicine code describing the service following applicable payer and CPT/HCPCS rules, just as you would if the patient was located in an office, outpatient hospital setting, etc. When coding for Telemedicine we are capturing the professional fee for the providers service. This does not change because the patient is now located in their home.

References / Links:

NA

Question:

My understanding is that in order to qualify for telehealth visit the physician must be in office. Is this true?

Answer:

No. There are no payment restrictions on distant site practitioners furnishing Medicare telehealth services from their home. The practitioner is required to update their Medicare enrollment with the home location. The practitioner can add their home address to their Medicare enrollment file by reaching out to the Medicare Administrative Contractor in their jurisdiction through the provider enrollment hotline. It would be effective immediately so practitioners could continue providing care without a disruption. More details about this enrollment requirement can be found at 42 CFR 424.516.

If the physician or non-physician practitioner reassigns their benefits to a clinic/group practice, the clinic/group practice is required to update their Medicare enrollment with the individuals' home location. The clinic/group practice can add the individual's home address to their Medicare enrollment file by reaching out to the Medicare Administrative Contractor in their jurisdiction through the provider enrollment hotline.

References / Links:

https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf

Question:

Per the Q&A Live webinar, can you provide confirmation that Medicare uses U codes and other payers use 87635?

Answer:

While CMS requires HCPCS codes when available the eporting of CPT codes vs. HCPCS codes varies by Commerical payer and the patient's insurance plan. Some payers will follow CMS guidance and request reporting of HCPCS codes. You will need to check payer information to determine which codes are most appropriate for reporting.

References / Links:

NA

Question:

Do you have a resource so that we have something in writing stating that telehealth is voice-only? Most of the payers I have seen have specified that telehealth requires audio and video, even before this crisis.

Answer:

On March 30, 2020 as part of the expansions to regulations for treatment during the COVID-19 pandemic CMS stated "Providers also can evaluate beneficiaries who have audio phones only". Commerical payers may vary in their requirements.

References / Links:

https://www.cms.gov/newsroom/press-releases/trump-administration-makes-sweeping-regulatory-changes-help-us-healthcare-system-address-covid-19

Question:

Are there any HIPAA guidelines we need to be aware of when the physician is speaking to the patient from home phone?

Answer:

The US Department of Health & Human Services has provided guidance in the form of FAQs and publications on their website.

References / Links:

https://www.hhs.gov/hipaa/for-professionals/special-topics/hipaa-covid19/index.html

Question:

Patient presents with symptoms, but no DX of infection, labs confirm postive COVID19. No known exposure to another identified. What would code selection be?

Answer:

For dates of service on or after April 1, 2020 the proper code selection will be U07.1, COVID-19. U07.1 was developed by the World Health Organization (WHO) and is intended to be sequenced first followed by the appropriate codes for associated manifestations when COVID-19 meets the definition of principal or first-listed diagnosis.

For cases prior to April 1, 2020 please follow the CDC ICD-10-CM Interim Advice on COVID-19 as code selection will vary, depending on the patients symptoms and/or conditions identified as related to Coronavirus.

References / Links:

https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf

https://journal.ahima.org/ahima-and-aha-faq-on-icd-10-cm-coding-for-covid-19/

Question:

If a physician documents "screening" for COVID19 no conditions listed. Is Z11.59 appropriate? If not, what do you recommend? No labs results are available at time of coding.

Answer:

The recommendation for this scenario from the American Hospital Association and American Health Information Management Association states providers should "consider developing facility-specific coding guidelines to hold back coding of inpatient admissions and outpatient encounters until the test results for COVID-19 testing are available. This advice is limited to cases related to COVID-19."

References / Links:

https://journal.ahima.org/ahima-and-aha-faq-on-icd-10-cm-coding-for-covid-19/

Question:

If the patient is admitted with acute respiratory failure d/t pneumonia d/t covid-19 and 4 days later they develop ARDS can we code both as there is an excludes1 note?

Answer:

ARDS is a definitive diagnosis classified by the code J80 and is a type of respiratory failure characterized by rapid onset of widespread inflammation of the lungs.

In this scenario, once the diagnosis of ARDS is made it would no longer be appropriate to capture the acute respiratory failure diagnosis, and this is the reason for the Excludes 1 notation.

For dates of service before April 1, 2020 you would capture ICD-10-CM J80, ARDS followed by B97.29, Other coronavirus as the cause of diseases classified elsewhere.

For dates of service on or after April 1, 2020 you would capture ICD-10-CM codes U07.1, COVID-19 and J80, ARDS

References / Links:

https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf

https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf

Question:

Can you provide the info on what modifiers are waived during the COVID emergency again please? thank you

Answer:

Only Modifier CR is waived, in addition to Condition code DR.

From source:

Note: Unlike other claims for which Medicare payment is based on a "formal waiver," telehealth claims don't require the "DR" condition code or "CR" modifier. CMS is not requiring additional or different modifiers associated with telehealth services furnished under these waivers. However, consistent with current rules, there are three scenarios where modifiers are required on Medicare telehealth claims. In cases when a telehealth service is furnished via asynchronous (store and forward) technology as part of a federal telemedicine demonstration project in Alaska and Hawaii, the GQ modifier is required. When a telehealth service is billed under CAH Method II, the GT modifier is required. Finally, when telehealth service is furnished for purposes of diagnosis and treatment of an acute stroke, the G0 modifier is required.

References / Links:

https://www.cms.gov/files/document/se20011.pdf

Question:

Does the MD's home address need to be on the claim?

Answer:

The practitioner is required to update their Medicare enrollment with the home location. The practitioner can add their home address to their Medicare enrollment file by reaching out to the Medicare Administrative Contractor in their jurisdiction through the provider enrollment hotline. It would be effective immediately so practitioners could continue providing care without a disruption. More details about this enrollment requirement can be found at 42 CFR 424.516.

If the physician or non-physician practitioner reassigns their benefits to a clinic/group practice, the clinic/group practice is required to update their Medicare enrollment with the individuals' home location. The clinic/group practice can add the individual's home address to their Medicare enrollment file by reaching out to the Medicare Administrative Contractor in their jurisdiction through the provider enrollment hotline.

References / Links:

https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf

Question:

We know to use POS 02 even if the MD is at his/her personal home. What we need to know is if that location needs to be payer credentialed (like other sites they would perform services)? And most importantly, does the MD's personal home address need to b

Answer:

The practitioner is required to update their Medicare enrollment with the home location. The practitioner can add their home address to their Medicare enrollment file by reaching out to the Medicare Administrative Contractor in their jurisdiction through the provider enrollment hotline. It would be effective immediately so practitioners could continue providing care without a disruption. More details about this enrollment requirement can be found at 42 CFR 424.516.

If the physician or non-physician practitioner reassigns their benefits to a clinic/group practice, the clinic/group practice is required to update their Medicare enrollment with the individuals' home location. The clinic/group practice can add the individual's home address to their Medicare enrollment file by reaching out to the Medicare Administrative Contractor in their jurisdiction through the provider enrollment hotline.

References / Links:

https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf

Question:

Can you address the use of code U70.2? None of the webinars I've been on have addressed the use of this code for suspected cases without confirmed laboratory testing.

Answer:

The WHO website reports this as a code, however there have been no publications to note it will be available April 1, 2020 as we have seen for ICD-10-CM Code U07.1. We do not anticipate ICD-10-CM code U07.2 to be released for use until October 1, 2020.

The American Hospital Association and American Health Information Management Association address this in their FAQ:

> *Question:* We have been told that the World Health Organization (WHO) has approved an emergency ICD-10 code of "U07.2 COVID-19, virus not identified." Is code U07.2 to be implemented in the US too? (rev. 3/26/2020)
>
> *Answer:* The HIPAA code set standard for diagnosis coding in the US is ICD-10-CM, not ICD-10. As shown in the April 1, 2020 Addenda on the CDC website, the only new code being implemented in the US for COVID-19 is U07.1.

References / Links:

https://journal.ahima.org/ahima-and-aha-faq-on-icd-10-cm-coding-for-covid-19/

Question:

If a patient presents with sepsis due to the Coronavirus which is the principle diagnosis? As is practice today, sepsis would be principle but I have been reading that Coronavirus would be principle. Can you please advise?

Answer:

According to guidance from AHIMA, ICD-10 code U07.1 is a principle diagnosis code. However, ICD-10-CM guidelines tell us that sepsis is present upon admission and the patient has a localized infection (such as pneumonia due to COVID), a code(s) for the underlying systemic infection (A41.89) should be assigned first and the code for the localized infection (e.g.pneumonia due to COVID) should be assigned as a secondry diagnosis. AHIMA tells us we cannot use U07.1 as a secondary code, but I suspect that will change. At this time our best guidance is to capture U07.1 as primary. We anticipate further guidance from WHO and the CDC before the effective date on April 1, 2020 and will be providing those as resources when available.

References / Links:

https://journal.ahima.org/ahima-and-aha-faq-on-icd-10-cm-coding-for-covid-19/

Question:

When doing an AWV by virtual telecommunication what guidelines do you follow for vital signs?

Answer:

If the provider is not able to complete vital signs, then this part of the AWV cannot be documented.

The patients visit with the medical provider should be as close to an in-person visit as possible. For example, when a present to the doctor's office, one of the first things that usually happens is the patient vital signs are taken. (temperature, heart rate, blood pressure, pulse oximetry/oxygen saturation). Telemedicine encounter should not be different. If a patient has fever and fast heart rate, this will influence the medical decision making.

Suggestions during the COVID-19 emergency would be to document any detail you receive during the visit. If patients have some type of digital devices handy (blood pressure, thermometer, etc) they can use the equipment with a digital display and show it over the video communication. Even if a video visit is not being performed, and the patient states they have a device to perform, it would be helpful for the medical provider to know what a patient's heart rate, temperature, blood pressure, and possibly pulse oximeter reading.

The fact that the patient can provide the vital signs based on the digital device would need to be documented in the record.

References / Links:

NA

Question:

Has a CPT been assigned for the new point of care test for COVID-19?

Answer:

A revision of code 86318, the addition of two Category I Pathology and Laboratory codes (86328, 86769), a revision of guidelines, and the addition of three parenthetical notes following codes 86328, 86635, and 86769 were accepted at the April 2020 CPT Editorial Panel meeting for testing of Severe Acute Respiratory Syndrome Coronavirus 2

References / Links:

https://www.ama-assn.org/system/files/2020-04/coronavirus-long-descriptors.pdf

Question:

For Medicare, modifier 95 is not required per information I have read. Can they confirm this?

Answer:

Yes, modifier 95 is required. Please see MLN Connects Special Edition April 3, 2020 for instructions regarding the use of a place of service code for those services newly added to the list of approved telehealth services.

References / Links:

https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-03-mlnc-se

Question:

What place of service should we be using for telephone calls, virtual check-ins, and e-visits? We are using '02' for telehealth as we were before this crisis.

Answer:

Traditional telehealth services should be reported with a place of service of "02" while other codes newly approved for telehealth services should be reported with the place of service it would have been reported with prior to the Public Health Emergency. Virtual check-in visits would generally be reported with "11 (Office)."

References / Links:

https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-03-31-mlnc-se

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Question:

Regarding coding for possible exposure to COVID-19, if a patient comes to the ED with symptoms of fever and cough and are concerned due to possible unconfirmed exposure to COVID-19 through a friend or family member, would code Z03.818 be warranted or just the fever and cough? Note, the provider was unable to perform a lab test for the COVID-19, just a chest xray was performed.

Answer:

It would not be appropriate to assign Z03.818 as ICD-10-CM codes from the Z03 category are to be used, "…when a person without a diagnosis is suspected of having an abnormal condition, without signs or symptoms, which requires study, but after examination and observation, is ruled out," according the ICD-10-CM instructional note associated with the Z03 series of codes. In the scenario described, it would be most appropriate to assign the sign and symptoms the patient is experiencing, so the fever and cough. Please see the ICD-10-CM Official Coding and Reporting Guidelines April 1, 2020 through September 30, 2020, Chapter 1: Certain Infectious and Parasitic Diseases (A00-B99) g. Coronavirus Infections, 1) COVID-19 Infections (Infections due to SARS-CoV-2), f) Signs and symptoms without definitive diagnosis of COVID-19

References / Links:

https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf

Question:

I know it's really short notice, but do you have any information regarding the CR modifier? Our facility seems to be in a tailspin trying to figure it out… any information if you can give any is greatly appreciated.

Answer:

See MLN Matters SE20011 Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19) Updated 4/10/2020. As a reminder, CMS is not requiring the CR modifier on telehealth services.

"Also, practitioners should add the modifier "CR" to professional claims for patients treated in temporary expansion site during the Public Health Emergency."

Use of the "DR" condition code and "CR" modifier are mandatory for institutional and non-institutional providers in billing situations related to COVID-19 for any claim for which Medicare payment is conditioned on the presence of a "formal waiver" (as defined in the CMS Internet Only Manual, Publication 100-04, Chapter 38, § 10). The DR condition code is used by institutional providers only, at the claim level, when all of the services/items billed on the claim are related to a COVID-19 waiver. 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.

References / Links:

https://www.cms.gov/files/document/se20011.pdf

https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

Question:

Since the results are not ready during the visit and if the results are returned positive, I would assume we have to query the physician. Is there a query recommendation form available we could use to query the physician?

Answer:

AHIMA has released downloadable templates for use when querying physicians (see resource). American Hospital Association and American Health Information Management Association has also stated providers should "consider developing facility-specific coding guidelines to hold back coding of inpatient admissions and outpatient encounters until the test results for COVID-19 testing are available. This advice is limited to cases related to COVID-19." Each organization will need to determine the best way to handle these scenarios

References / Links:

https://ahima.realmagnet.land/covid-19-query-templates-professional

https://journal.ahima.org/ahima-and-aha-faq-on-icd-10-cm-coding-for-covid-19/

Question:

We are conducting all of our encounters by telephone only, in the practices as well as in Express care. Can you clarify whether we can use E/M's or whether these are considered Virtual check-in calls

Answer:

You should report servives provided by telephone only for Medicare/Medicaid patients with CPTs 99441-99443. Individual commerical payers may allow for E/Ms to be billed with only audio is used, however CMS still requires both audio/visual to be utilzied in order to capture Telehealth services.

References / Links:

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf

Question:

Can you explain the difference between an e-visit and a telehealth visit? What code would you use if speech therapist had an audio visiual visit with a patient? @ould it still be in the G2061-G2063 area?

Answer:

An e-visit is a non face to face patient initiated digital communication that requires clinical decisions that otherwise typically would have been provided in the office. These visits are conducted online or via a digital platform, which telehealth visits are completed using audio/visual connection between the patient and provider.

For speech therapists, we recommend reporting CPT codes 92507- Speech/heating therapy, 92521- Eval of speech fluenc. 92522- Eval speech production, and/or 92523- Speech lang comprehension. These CPT codes are included in CMS's updated list of telehealth approved codes (see resource).

References / Links:

https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf

Question:

The latest guideline release reflects coding confirmed COVID 19 cases as 1)documented by the provier, 2) documentation of a positive COVID 19 test result or 3) a presumptive positive COVID 19 test result.

Could you please clarify if this statement is an exemptionto the guideline re: laboratory results needing interpretation by a physician for OBS/outpatient cases or must the physician still provide documentation of the positive or presumptive positive finding to code?

Could documentation of positive test result be coded if provided by a nurse?

Answer:

The recommendation for this scenario from the American Hospital Association and American Health Information Management Association states providers should "consider developing facility-specific coding guidelines to hold back coding of inpatient admissions and outpatient encounters until the test results for COVID-19 testing are available. This advice is limited to cases related to COVID-19."

References / Links:

https://journal.ahima.org/ahima-and-aha-faq-on-icd-10-cm-coding-for-covid-19/

Question:

Should COVID-19 Lab results from previous ED admission be used for subsequent inpatient hospital admissions? Inpt record says COVID-19 results pending. Should this be kept on hold until results are back from ED admission?

Answer:

The recommendation for this scenario from the American Hospital Association and American Health Information Management Association states providers should "consider developing facility-specific coding guidelines to hold back coding of inpatient admissions and outpatient encounters until the test results for COVID-19 testing are available. This advice is limited to cases related to COVID-19."

References / Links:

https://journal.ahima.org/ahima-and-aha-faq-on-icd-10-cm-coding-for-covid-19/