

**DISCLAIMER**

This document is intended to provide a consolidated update on the rapidly shifting changes in regulatory requirements related to COVID-19. Click [here](#) for tip sheets and guidance on specific patient care or documentation and billing/coding workflows being implemented at UCM which are not covered in this document. To access the most current version of this document, click [here](#). Questions can be sent to [compliance@bsd.uchicago.edu](mailto:compliance@bsd.uchicago.edu).

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**UPDATES 11-12-20**

- **CMS COVID-19 Stakeholder Engagement Calls (twice a month on Tuesdays at 4:00-5:00 PM Central: November 17, Toll Free-Dial In 833-614-0820; Access Passcode 2491556; Webcast [link](#)**
- **Interim Final Rule: COVID-19 Vaccine/Treatment Coverage:** US Dept of Treasury, Labor, and HHS published a fourth COVID-19 Interim Final Rule with comment period in the Federal Register ([CMS-9912-IFC](#)). The effective date for the majority of the provisions is Nov. 2, 2020. Comments are due Jan. 4, 2021. This interim final rule:
  - ⇒ Implements several aspects of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), including COVID-19 vaccine payment and administration;
  - ⇒ Establishes Medicare add-on payments for new COVID-19 treatments under the inpatient and outpatient prospective payment systems (IPPS and OPSS);
  - ⇒ Implements Medicaid beneficiary enrollment maintenance requirements from the Families First Coronavirus Response Act (FFCRA);
  - ⇒ Extends the Comprehensive Care for Joint Replacement model by 6 months; and Revises regulations specific to State Innovation Waivers.

CURRENT UPDATES 11-12-20

**State Licensure Table for Telehealth**

CMS (federal) waivers for licensure do not align with licensure (state) requirements.

- ⇒ Indiana requires a temporary license: providers have been asked to register on [Indiana's Temporary Provider Registry](#) by 11/13/2020. Detailed instructions can be found [here](#).
- ⇒ Wisconsin, similar to Indiana, requires completion of a notification [form](#) with the state's Department of Safety and Professional Services.
- ⇒ At this time, we are unable to provide telehealth services for Michigan residents

OCC will maintain a list of state licensure requirements, which can be found [here](#).

**COVID-19: Non-Physician Practitioner Billing for CPT Codes 98966-98968**

Per [MLN Connects Newsletter](#), during the COVID-19 PHE, non-physician practitioners who are eligible to bill Medicare directly, including registered dietitians and nutrition professionals, may bill for audio-only telephone assessment and management services:

Applicable CPT codes 98966-98968. Applies to dates of service on or after March 1 until the end of the PHE

**COVID-19: CMS payment for CPT 99072 (additional supplies, materials and clinical staff)**

Per [MLN Matters 11939](#), released October 27, 2020, CMS has determined that CPT 99072 is a bundled code. Therefore there are no RVUS and separate payment for this CPT 99072.

*Code Descriptor: Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency as defined by law, due to respiratory-transmitted infectious disease*

**CMS announces Medicare beneficiaries can receive COVID-19 Antibody Treatment with no cost sharing**

CMS announced that starting November 10, Medicare beneficiaries can receive coverage of monoclonal antibodies to treat COVID-19 with no cost-sharing during the PHE. CMS' coverage of monoclonal antibody infusions applies to bamlanivimab, which received an Emergency Use Authorization (EUA) from the FDA on November 9. Click [here](#) for more details. View the [Monoclonal Antibody COVID-19 Infusion Program Instruction](#).

**PROPOSED PHYSICIAN FEE SCHEDULE FOR CY21**

On August 3, 2020, CMS issued a Proposed Rule describing potential policy changes for Medicare payments under the Physician Fee Schedule (PFS), and other Medicare Part B issues, on or after January 1, 2021. The changes described in the Proposed Rule are not final.

**HIGHLIGHTS**

1. **Conversion Factor:** CY 2021 PFS conversion factor is \$32.26, a decrease of \$3.83 from the CY2020 PFS conversion factor of \$36.909.
2. **CMS Telehealth Services:** CMS has chosen to not extend the use of the vast majority of the codes that were temporarily added to CMS' telehealth list during the PHE, including physical therapy, occupational therapy, behavioral codes, speech/audiology codes, observation care, critical care. Below, are the codes that CMS is proposing to retain either permanently or temporarily:
  - **Codes CMS recommends making permanent telehealth codes (Category 1 codes):**
    - Visit Complexity Associated with Certain Office/Outpatient E/Ms – HCPCS code GPC1X
    - Group Psychotherapy- HCPCS code 90853
    - Neurobehavioral Status Exam – HCPCS code 96121
    - Care planning for patients with cognitive impairment – HCPCS code 99483
    - Domiciliary, Rest Home, or Custodial Care Services – HCPCS code 99334, 99335
    - Home Visits- HCPCS code 99347, 99348
  - **Codes that will remain on CMS' telehealth list only through the calendar year in which the PHE ends (aka "Category 3" codes):**
    - Domiciliary, Rest Home, or Custodial Care Services, Established patients – HCPCS code 99336, 99337
    - Home Visits, Established patients- HCPCS code 99350
    - Emergency Department Visits- HCPCS code 99281, 99282, 99283
    - Nursing facilities discharge day management- HCPCS code 99315, 99316
    - Psychological and Neuropsychological Testing- HCPCS code 96130, 96131, 96132, 96133
3. **Telephone E/M Codes will end with the PHE:** CMS is not proposing to extend the use of telephone E/M codes beyond the duration of the PHE. However, recognizing the need for audio-only services, it is seeking comment on whether it should develop coding and payment for services similar to virtual check-ins but for a longer unit of time an higher value.
4. **Telehealth Clarifications:**
  - **LCSW, CPs, PTs, Ots, SLPs:** These practitioners can furnish the brief online assessment and management services as well as virtual check-ins and remote evaluation services. In order to facilitate billing by these practitioners for the remote evaluation of patient-submitted video or images and virtual check-ins (HCPCS codes G2010 and G2012) we are proposing to use two new HCPCS G codes.
  - **Telehealth does not apply when patient and practitioner are in same location:** We are reiterating in this proposed rule that telehealth rules do not apply when the beneficiary and the practitioner are in the same location even if audio/video technology assists in furnishing a service.
5. **Changes or clarifications made during the PHE that CMS proposes making permanent through the CY 2021 PFS:**
  - **Supervision of Diagnostic tests by Certain Nonphysician Practitioners (NPPs):** Nurse practitioners (NPs), clinical nurse specialists (CNSs), physician assistants (PAs) and certified nurse-midwives (CNMs) may supervise the performance of diagnostic tests in addition to physicians.
  - **Pharmacists Providing Services Incident to Physicians' Services:** CMS clarified in the May 1<sup>st</sup> COVID-19 IFC (85 FR 27550 through 27629), that pharmacists fall within the regulatory definition of auxiliary personnel under our "incident to" regulations. As such, pharmacists may provide services incident to the services, and under the appropriate level of supervision, of the billing physician or NPP, if payment for the services is not made under the Medicare Part D benefit. This includes providing the services incident to the services of the billing physician or NPP and in accordance with the pharmacist's state scope of practice and applicable state law.
  - **Therapy Assistants Furnishing Maintenance Therapy:** A physical therapist (PT) and occupational therapist (OT) has the discretion to delegate the performance of maintenance therapy services, as clinically appropriate, to a therapy assistant – a physical therapist assistant (PTA) or an occupational therapy assistant (OTA).
  - **Medical Record Documentation:** In this CY 2021 PFS proposed rule, CMS is clarifying that physicians and NPPs, including therapists can review and verify documentation entered into the medical record by members of the medical team for their own services that are paid under the PFS. CMS is also clarifying that therapy students, and students of other disciplines, working under a physician or practitioner who furnishes and bills directly for their professional services to the Medicare program, may document in the record so long as it is reviewed and verified (signed and dated) by the billing physician, practitioner, or therapist.

# OCC COVID-19 COVERAGE AND PAYMENT GUIDANCE (Updated 11-12-20)

## HIGHLIGHTS OF THE PROPOSED PHYSICIAN FEE SCHEDULE FOR CY21, Continued

### **6. Changes made during the PHE that CMS is proposing to extend to Dec 31, 2021**

- **Direct Supervision by Interactive Telecommunications Technology:**
  - \* Proposing to allow direct supervision to be provided using real-time, interactive audio/video real-time communication technology (excluding telephone that does not also include video) through December 31, 2021.
  - \* Asking for comments about risk to patients, additional guardrails that may be needed, or if it should be extended beyond Dec 31, 2021.
- **Teaching Physician Policies:** CMS is considering whether TP policies implemented during the PHE should be extended on a temporary basis (that is, if the PHE ends in 2021, these policies could be extended to December 31, 2021 to allow for a transition period before reverting to status quo policy) or be made permanent, and are soliciting public comments on whether these policies should continue once the PHE ends. Relevant policies include:
  - \* During the PHE, the TP may use audio/video real time communications technology to interact with the resident through virtual means, which would meet the requirement that they be present for the key portion of the service, including when the teaching physician involves the resident in furnishing Medicare Telehealth services.
  - \* Teaching physicians involving residents in providing care at primary care centers can provide the necessary direction, management and review for the resident's services using audio/video real time communications technology.
  - \* Residents furnishing services at primary care centers may furnish an expanded set of services to beneficiaries, including levels 4-5 of an office/outpatient evaluation and management (E/M) visit, care management, and communication technology-based services.

### **7. Payment for Office/Outpatient E/M and Analogous Visits**

- As finalized in the CY2020 PFS Final Rule, beginning January 1, 2021, CMS is largely aligning E/M visit coding and documentation policies with changes laid out by the CPT Editorial Panel for Office/Outpatient visits.
- CMS is proposing a refinement to clarify the times for which **prolonged office/outpatient E/M visits can be reported**, and are proposing to revise the times used for rate setting for this code set.
- CMS is proposing to revalue additional code sets that rely upon or are analogous to office/outpatient E/M visits commensurate with the increase in values that were finalized for office/outpatient E/M visits for 2021:
  - \* End-Stage Renal Disease (ESRD) Monthly Capitation Payment (MCP) Services
  - \* Transitional Care Management (TCM) Services
  - \* Maternity Services
  - \* Cognitive Impairment Assessment and Care Planning
  - \* Initial Preventive Physical Examination (IPPE) and Initial and Subsequent Annual Wellness (AWV) Visits
  - \* Emergency Department Visits
  - \* Therapy Evaluations
  - \* Psychiatric Diagnostic Evaluations and Psychotherapy Services

### **8. New payment rules/clarifications for Remote Physiologic Monitoring and Immunization services**

**9. Clinical Laboratory Fee Schedule-** The data reporting period has been revised and the phase-in of payment reductions resulting from private payor rate implementation has been extended through CY2024.

**10. Medicare Shared Savings Program:** CMS is proposing changes to the Medicare Shared Savings Program (Shared Savings Program) quality performance standard and quality reporting requirements for performance years beginning on January 1, 2021 to align with Meaningful Measures, reduce reporting burden and focus on patient outcomes.

**The public may send comments to CMS using the methods below. To be assured consideration, comments must be received no later than 5 p.m. on October 5, 2020 . See [Press Release](#) for details. Click [here](#) for the unpublished version of the Proposed Rule (it is scheduled for publication on 8-17-20).**

**1. Electronically at <http://www.regulations.gov>.** Follow the "Submit a comment" instructions.

**2. By regular mail.** You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,  
Department of Health and Human Services,  
Attention: CMS-1734-P,  
P.O. Box 8016,  
Baltimore, MD 21244-8016.

**3. By express or overnight mail.** You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,  
Department of Health and Human Services,  
Attention: CMS-1734-P,  
Mail Stop C4-26-05,  
7500 Security Boulevard,

# OCC COVID-19 COVERAGE AND PAYMENT GUIDANCE (Updated 11-12-20)

## RESOURCES:

- [Interim Final Rule 4-30-20](#) and [CMS Press Release](#)
- [Interim Final Rule 3-31-20](#)
- [CMS.GOV Coronavirus Waivers & Flexibilities](#)
- [List of Hospital Outpatient Services and List of Partial Hospitalization Program Services Accompanying the 4/30/2020 IFC \(ZIP\)](#) (4-30-20)
- [List of lab test codes for COVID-19, Influenza, RSV \(PDF\)](#) (4-30-20)
- [Medicare Telehealth Services](#)
- [AAMC letter to CMS dated 5-15-20](#): Changes AAMC would like to see extended or made permanent once the crisis is over.

## Highlights of the Interim Final Rule Published by CMS 4-30-20

### During the COVID-19 PHE, CMS is allowing on-campus and excepted off-campus Provider Based Departments (PBDs) to temporarily relocate to new off-campus locations, including the patient's home

- Relocated PBDs may begin furnishing and billing for services under the OPDS in the new location using modifier PO on the OPDS claim. Hospitals may relocate HOPDs to more than one off-campus location, or partially relocate off-campus while still furnishing care at the original site. *(Note: Workflows at UCM are currently being designed to address this change)*

### Scope of Practice expanded for NPPs, Therapists and Pharmacists

- All health care professionals that can furnish distant site telehealth services may bill Medicare for their professional services, including physical therapists, occupational therapists, speech language pathologists and others. *(Note: Workflows at UCM are currently being designed to address this change)*
- NPs, CNS, PAs, CNMs may supervise diagnostic tests
- NP, CNS, and PA may certify and supervise Medicare home health benefit
- Maintenance therapy may be delegated to PTAs and OTAs
- Pharmacists may provide services incident to the services of a physician and NPP

### Medicare Telehealth Changes

- 46 new services added to Telehealth List, including Telephone E/M (99441-99443), Eye exams, and Therapy Services
- Payment increased for Telephone E/M codes 99441-99443 to the equivalent of 99212-99214. Increases payment from about \$14-\$41 to about \$46-\$110. Retroactive to 3-1-20.
- Certain telehealth services can be provided with audio only
- Hospitals can bill for telehealth services in relocated Provider Based Departments (including the patient's home) if patient is a registered outpatient.
- See [CMS' updated Telehealth list](#) for details

### Primary Care Teaching Physician Changes

- Codes that can be billed under the PCE now include:
  - \* 99441-99443 (telephone codes)
  - \* 99421-99423 (MyChart codes)
  - \* 99495-99496 (Transitional Care Management Services)
  - \* 99452 (Inter-professional telephone/internet/electronic health record referral services- 30 minutes)
  - \* G2012 and G2010 (virtual check-in and remote evaluation of recorded images)
- CMS clarified that for PCE services, Teaching Physician may review the Resident's services immediately *after* the visit using real-time audio/video technology

### COVID-19 Diagnostic Testing, Ordering and Reimbursement

- COVID-19 diagnostic tests, and related influenza/respiratory tests may be ordered by any clinician allowed by the State
- CMS will pay for FDA authorized COVID-19 serology testing
- CMS will pay Professional Practices for specimen collection by clinical staff incident to a physician or NPP- bill with CPT 99211
- CMS will pay Hospital Outpatient Departments for specimen collection by clinical staff with new HCPCS code C9803

### Clinical Indications for Therapeutic Continuous Glucose Monitors:

CMS will not enforce clinical indications for coverage found in NCDs/LCDs related to therapeutic continuous glucose monitors.

**Payment for Remote Physiologic Monitoring (RPM) Services Furnished During the PHE:** CMS will pay for RPM monitoring for periods of time that are fewer than 16 days of 30 days, but no less than 2 days, as long as the other requirements for billing the code are met.

**Home Health Services:** A NP, CNS, and PA may now certify, establish and periodically review the plan of care, as well as supervise the provision of items and services for beneficiaries under the Medicare home health benefit.

**Medical Education Payments due to COVID-19 :** CMS is modifying its method of calculating DGME/ IME payments to account for increases in beds due to COVID-19, and allow hospitals to claim the time spent by residents training at another hospital for purposes of GME payments.

### Medicare Shared Saving Program (MSSP):

- Removes payment amounts for COVID-19 episodes of care (identified by inpatient acute care) to mitigate the impact of COVID-19 care on various financial performance calculations.
- Adds telehealth specific codes to the definition of primary care services used in patient attribution to ACOs beginning in January 2020 through the remainder of the PHE.
- Corrects prior misstatement on the timeline for the application of the Program's extreme and uncontrollable circumstances policy, which is effective beginning January 2020 (not March 2020) based on the timing of the Secretary's declaration of the PHE.
- Cancels the 2021 application cycle and allows ACOs whose current agreements expire at the end of 2020 to extend those agreements through 2021 to decrease burden.

**CMS BLANKET WAIVERS FOR HOSPITALS DURING COVID-19 PHE**

For details , go to [CMS' List of Blanket Waivers \(PDF\) UPDATED \(5/11/20\)](#)

• **Flexibility for Medicare Telehealth Services (New since 4-21 release)**

- ⇒ **Eligible Practitioners:** All health care professionals that can furnish distant site telehealth services may bill Medicare for their professional services, including Physical therapists, occupational therapists, speech language pathologists and others.
- ⇒ **Audio-only Telehealth for Certain Services:** Allows use of audio-only equipment for telephone EM, behavioral health counseling and educational services. See designated codes [here](#).

• **Hospitals**

- ⇒ **EMTALA:** Hospitals may screen patients at a location offsite from the hospital's campus to prevent the spread of COVID-19
- ⇒ **Verbal Orders:** Waiver of requirements related to verbal orders to allow flexibility during patient surges.
- ⇒ **Reporting Requirements:** Waiver of requirement that hospitals report patients in an ICU whose death is caused by their disease, but who required soft wrist restraints to prevent pulling tubes/IVs, no later than the close of business on the next business day.
- ⇒ **Patient Rights:** for hospitals impacted by an outbreak of COVID-19, CDC reporting requirements waived.
- ⇒ **Sterile Compounding:** Waiver of certain requirements to allow used face masks to be removed and retained in the compounding area to be re-donned and reused during the same work shift in the compounding area only.
- ⇒ **Detailed Information Sharing for Discharge Planning for Hospitals:** Waiver of certain requirements to provide detailed information regarding discharge planning, including a list of HHAs, SNFs, IRFs, or LTCHS and quality and resource use measures.
- ⇒ **Medical Staff:** Physicians whose privileges will expire may continue practicing at the hospital and new physicians may practice before full medical staff/governing body review.
- ⇒ **Medical Records::** Waiver of medical record requirements as long as they aren't inconsistent with the state's emergency preparedness or pandemic plan.
- ⇒ **Flexibility in Patient Self Determination Act Requirements (Advance Directives):** Waiver of requirement for hospitals to provided information about advance directive policies to patients.
- ⇒ **Physical Environment:** non-hospital spaces may be used for patient care and quarantine sites.
- ⇒ **Telemedicine:** Waiving provisions to make it easier for telemedicine services to be furnished to the hospital's patients through an agreement with an off-site hospital.
- ⇒ **Physician Services:** Medicare patients do not have to be under the care of a physician so that other practitioners can be used to the fullest extent possible.
- ⇒ **Anesthesia Services:** CRNAs do not require physician supervision which will allow the CRNA to function to the fullest extent of their licensure.
- ⇒ **Utilization Review:** Relaxation of utilization review plan requirements.
- ⇒ **Written Policies and Procedures for Appraisal of Emergencies at Off Campus Hospital Departments:** emergency services with respect to surge facilities only, do not require written policies and procedures for staff to use when evaluating emergencies.
- ⇒ **Emergency Preparedness Polices and Procedures:** Waiver of requirements which requires the hospital to develop and implement emergency preparedness policies and procedures with respect to surge sites.
- ⇒ **Quality Assessment and Performance Improvement Program:** Flexibilities implemented to decrease burden on hospitals to maintain such programs.
- ⇒ **Nursing Services:** Waiver of nursing plans and related polices and procedures.
- ⇒ **Food and Dietetic Services:** Therapeutic diet manuals not required at surge capacity sites.
- ⇒ **Respiratory Care Services:** Waiver of requirements that require hospitals to designate in writing the personnel qualified to perform specific respiratory care procedures and the amount of required supervision.
- ⇒ **Expanded Ability for Hospitals to Offer Long-term Care Services ("Swing-Beds") for Patients Who do not Require Acute Care but do Meet the SNF Level of Care Criteria (New since 4/30 release)**
- ⇒ **Temporary Expansion Locations:** Waiver of certain conditions of participation to allow hospitals to establish and operate as part of the hospital any location, and allow hospitals to change the status of their current provider-based department locations to address the needs of patients.
- **Practitioner Locations:** Temporary waiver that physicians and non-physician practitioners be licensed in the state where they are providing services . State requirements for licensure issues still apply.
- **Provider Enrollment:** Establish a toll-free hotline for non-certified Part B suppliers, physicians and non-physician practitioners to enroll and receive temporary Medicare billing privileges; waiver of certain screening requirements.
- **Medicare Appeals in Fee for Service, Medicare Advantage and Part D:** MACs and QIOs may allow extensions to file for an appeal, and flexibility during the appeals process.

## ADDITIONAL FLEXIBILITIES FROM CMS DURING THE COVID-19 PHE

**Accelerated /Advance Payments:** CMS is authorized to provide accelerated or advance payments during the period of the PHE to any Medicare provider/supplier who submits a request to the appropriate Medicare Administrative Contractor (MAC) and meets the required qualifications. Each MAC will work to review requests and issue payments within seven calendar days of receiving the request. The repayment of these accelerated/advance payments begins 120 days after the date of issuance of the payment (normally 90 days). More information is available at [www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf](http://www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf).

**Beneficiary Notice Delivery Guidance in light of COVID-19:** In light of concerns related to COVID-19, CMS has provided some flexibilities for delivering the notices listed below to beneficiaries in isolation. Review the [MLN Special Edition 3-26-20](#) for details.

- Important Message from Medicare
- Detailed Notices of Discharge (DND)
- Notice of Medicare Non-Coverage
- Detailed Explanation of Non-Coverage
- Medicare Outpatient Observation Notice
- Advance Beneficiary Notice of Non-Coverage
- Skilled Nursing Advance Beneficiary Notice of Non-Coverage
- Hospital Issued Notices of Non-Coverage

**Cost Reporting:** CMS is delaying the filing deadline of certain cost report due dates due to the COVID-19 outbreak. CMS is currently authorizing delay for the following fiscal year end (FYE) dates. CMS will delay the filing deadline of FYE 10/31/2019 cost reports due by March 31, 2020 and FYE 11/30/2019 cost reports due by April 30, 2020. The extended cost report due dates for these October and November FYEs will be June 30, 2020. CMS will also delay the filing deadline of the FYE 12/31/2019 cost reports due by May 31, 2020. The extended cost report due date for FYE 12/31/2019 will be July 31, 2020. See CMS' [Press Release](#).

### **Merit-Based Incentive Payment System (MIPS)**

- **4-20-20: Clinicians who participate in a COVID-19 clinical trial can receive credit for Merit-based Incentive Payment System (MIPS):** In order to receive credit for the new MIPS *COVID-19 Clinical Trials* improvement activity, clinicians must attest that they participate in a COVID-19 clinical trial utilizing a drug or biological product to treat a patient with a COVID-19 infection and report their findings through a clinical data repository or clinical data registry for the duration of their study. Clinicians who report this activity will automatically earn half of the total credit needed to earn a maximum score in the MIPS improvement activities performance category, which counts as 15 percent of the MIPS final score. Read further details in [CMS' Press Release](#).
- CMS is offering multiple flexibilities to provide relief to clinicians responding to the 2019 Novel Coronavirus (COVID-19) pandemic. In addition to extending the 2019 Merit-based Incentive Payment System (MIPS) data submission deadline to April 30 at 8 pm ET, the MIPS automatic extreme and uncontrollable circumstances policy will apply to MIPS eligible clinicians who do not submit their MIPS data by the April 30 deadline.
- CMS is also reopening the [MIPS extreme and uncontrollable circumstances application](#) for individuals, groups, and virtual groups. An application submitted by April 30, citing COVID-19 will override any previous data submission.
- For more information, [Quality Payment Program COVID-19 Response Fact Sheet](#)
- For details of *all* affected quality reporting programs, see CMS' [Press Release](#) dated March 22, 2020.

### **Open Payments: COVID-19 Update**

CMS cannot extend the pre-publication review and dispute period, but covered recipient review and dispute actions can be completed within the Open Payments system throughout the calendar year. During the PHE, CMS is committed to ensuring covered recipients are aware of and take advantage of their opportunity to review their data and dispute it if needed. Read the [Open Payments Pre-Publication Review and Dispute COVID-19 Announcement](#).

### **Billing Practitioners' Scope of Practice (Added per Interim Final Rule 4-30-20)**

- All health care professionals that can furnish distant site telehealth services may bill Medicare for their professional services, including physical therapists, occupational therapists, speech language pathologists and others.
- NPs, CNS, PAs, CNMs may supervise diagnostic tests, rather than just physicians.
- NP, CNS, and PA may now certify, establish and periodically review the plan of care, as well as supervise the provision of items and services for beneficiaries under the Medicare home health benefit
- PTs and OTs may delegate maintenance therapy to PTAs and OTAs
- Pharmacists may provide services incident to the services of a physician and NPP

## STATE OF ILLINOIS REGULATORY ACTION

Illinois Health and Hospital Association (IHA)**9-14-20 memo: Hospital Licensing Waivers Altered through Emergency Rules**

On September 4, IDPH filed emergency rules (Sept. 4 [Illinois Register](#), pages 14333 - 14349) repealing certain prior emergency rules related to Governor Pritzker's [Executive Order 2020-52](#), which extended many of the executive orders related to the COVID-19 pandemic, including hospital licensing waivers. This may have caused some confusion. Although the September 4 emergency rules repeal the existing emergency rules, several of the emergency waivers have, in fact, been extended under a separate emergency rule released on September 11 (Sept. 11 [Illinois Register](#), pages 14804 - 14823) and retroactive to August 24, including:

- Permitting hospitals to expand hospital capacity and/or re-allocated bed designations to accommodate need. Hospitals must still provide notification to IDPH within 30 days of this event;
- Several requirements related to patient rooms;
- The use of seclusion consistent with the emergency declaration by the Centers for Medicare Medicaid Services; and
- Continued use of alternate care facilities.

The Governor's executive order and the Department's updated emergency rules **did not extend** certain waiver provisions including:

- Notice of discharge for aged patients and patients with disabilities on Medicare
- Patient notice of observation status
- Opioid overdose reporting
- Arrangement for transportation of patient by an ambulance provider
- Requirements for employment of physicians
- Nurse staffing by patient acuity
- Television closed captioning
- All waivers related to the Hospital Report Card Act
- Training for phlebotomists on children and adults with intellectual and developmental disabilities
- Required offering of a uterine cytologic exam for every female inpatient 20 years of age or over
- The expansion of deadlines for reporting under the Illinois Adverse Health Care Events Reporting Law of 2005

**7-24-20:** Governor J.B. Pritzker issued a new 30-day COVID-19 [disaster proclamation](#), and [Executive Order #48](#) (reissuing many existing executive orders and extending them to Aug. 22).

**5-28-20: Governor reissues [Executive Order #39 \(COVID-19 Order #37\) \(Reissues Executive Orders\)](#)**, including Telehealth (Executive Order 2020-09) re-issued in its entirety and extended through June 27, 2020.

**5-21-20 IDPH Interim Guidance on MIS-C Associated with COVID-19:** IDPH has issued a new document on Multisystem Inflammatory Syndrome in Children (MIS-C) Associated with COVID-19. This document is aimed at ensuring that clinicians are aware of current guidance regarding MIS-C, including the case definition and guidance on essential actions, testing, and reporting to local health departments. [Click here](#) to see the full guidance.

**5-20-20 IHA Update on COVID-19 Private Payer Guidance** IHA has created a [table](#) that summarizes COVID-19 coverage of testing/screening and treatment for health plans offered by health insurance issuers operating in Illinois.

**Executive Order, 4/16/20** -Governor J.B. Pritzker issued an [executive order](#) instructing the Illinois Dept. of Public Health to exercise discretion regarding enforcement of all provisions of several Acts (See [IHA's summary](#) of the order)



STATE OF ILLINOIS REGULATORY ACTION

**Blanket Waivers March 20, 2020**, the IHA provided CMS with notice of the intent of each Illinois hospital and health system and their respective affiliates in Illinois to operate under certain [“blanket” waivers](#) issued by CMS. Click [here](#) to review IHA’s letter for full detail. Highlights include :

- **Licensure:** Waive the requirement that out-of-state providers be licensed in the state where they are providing services when they are licensed in another state. This applies to Medicare and Medicaid.
  - Click [here](#) for AAMC’s chart of licensure status of all 50 states dated 4/13/20
- **Skilled Nursing Facilities—3 day rule:** Waive the requirement for a 3 day prior hospitalization for coverage of a SNF stay .
- **Provider Enrollment-Screening Requirements:** Waiver of the following screening requirements-
  - ◇ Application Fee – 42.CFR 424.514
  - ◇ Criminal background checks associated with FCBC – 42 CFR424.518
  - ◇ Site visits- 42 CFR424.517
- **Medicare appeals in Fee for Service, MA and Part D:** Waive timeliness for requests for additional information to adjudicate the appeal.
- **Payment for out-of-network providers Section 1851(i):** Waive limitations on payments under section 1851(i) of the Act for health care items and services furnished to individuals enrolled in a MA plan by health care professionals or facilities not included in the plan’s network:
- **EMTALA Section 1867:** Waive sanctions for the direction or relocation of an individual to another location to receive medical screening pursuant to an appropriate state emergency preparedness plan or for the transfer of an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared Federal public health emergency for the COVID-19 pandemic.

**Department of Healthcare and Family Services (HFS)**

**CMS Waiver Requests:** On March 19, 2020, the Dept. of Healthcare and Family Services (HFS) submitted a [request](#) to CMS to waive certain federal Medicaid, CHIP, and HIPAA regulations. On March 23, 2020, CMS responded to some of the items in the request. It continues to work on responding to the other requests in the letter. Click [here](#) to view the response.

- [Provider Notice Issued 3/20/20 Telehealth Services Expansion Prompted by COVID-19](#): The notice informs providers of changes to telehealth policy due to COVID-19 PHE. Highlights include coverage of telehealth services delivered via audio/visual technology, as well as telephone, and inclusion of a patient’s place of residence as an originating site.
- [Provider Notice Issued 3/30/20 Telehealth Expansion Billing Instructions](#) HFS provided additional guidance and changes for telehealth, virtual check-in and online patient portal/E-visit billing based upon the policy identified in the provider notice 3-20-20.
- [HFS Memorandum 4/1/20 COVID-19 Telehealth Update #1: State coverage and reimbursement](#) : Summary of telehealth modifications as described in the Provider Notice issued 3/30/20.
- [Provider Notice Issued 4/6/20 Prior Authorization Requests](#) HFS has made changes to prior authorization requests and claims for participants covered under fee-for-service, [HealthChoice Illinois](#) managed care plans and the Medicare/Medicaid Alignment Initiative ([MMAI](#)) plans.
- [Provider Notice issued 5/18/20 COVID-19 Testing is Free to Illinois Residents](#)
  - ⇒ Providers must stop charging Illinois residents for COVID-19 tests or requiring a serology test for antibodies before testing
  - ⇒ **HFS Uninsured COVID-19 Testing Program:** reimburses health care providers who provide COVID-19 testing and testing-related services to uninsured individuals on or after March 18, 2020.
  - ⇒ **Reimbursement through HRSA:** Providers should use the HRSA program to request reimbursement for COVID-19 testing and testing-related services with dates of service between February 4 and March 17, 2020, as well as COVID-19 treatment provided on or after February 4, 2020.

TEACHING PHYSICIAN RULES/RESIDENTS DURING THE PHE

Resources

- [Interim Final Rule 3-31-20](#)
- [Interim Final Rule 4-30-20](#)
- [NGS Telehealth Billing FAQs](#)
- [CMS Teaching Hospital Flexibilities](#)

**TEACHING PHYSICIAN FLEXIBILITIES**

**Definition of “Direct Supervision”:** As currently defined in § 410.32(b)(3)(ii) direct supervision means that the physician must be present in the office suite and immediately and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

**Revised definition of “Direct Supervision”:** During the COVID-19 PHE, the presence of the physician includes *virtual presence through audio/video real-time communications technology when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider (from Section II.E. of the Interim Final Rule dated March 30)*

**Impact on Teaching Physician Regulations at § 415.172:** Under current rules, Medicare payment is made for services furnished by a teaching physician involving residents only if the physician is physically present for the key portion of the service or procedure or the entire procedure, where applicable. *During the PHE, 415.172 has been amended to allow that as a general rule the requirement for the presence of a teaching physician can be met, at a minimum, through direct supervision by interactive telecommunications technology as described in section II.E. of the Interim Final Rule dated March 30.*

**Impact on the Teaching Physician Primary Care Exception at § 415.174:** Under current rules, Medicare payment is made for services under the PCE if the TP directs the care of no more than four residents at any given time from such proximity as to constitute immediate availability. The TP must also have no other responsibilities at the time, assume management responsibility for those beneficiaries seen by the residents, ensure that the services furnished are appropriate; and review with each resident during or immediately after each visit, the beneficiary's medical history, physical examination, diagnosis, and record of tests and therapies. *During the PHE, 415.174 has been amended to allow that all levels of an office/outpatient E/M service provided in Primary Care Centers may be provided under “Direct Supervision”. Additionally, the TP may review the services provided with the resident, during or immediately after the visit, remotely through virtual means via audio/video real time communications technology.*

**Services that can be billed under the PCE:** Section 100 of Chapter 12 of the Medicare Claims Processing Manual specifies that the codes that can be furnished under the primary care exception include: 99201-99203, 99211-99213, HCPCS codes G0402, G0438, and G0439. The Interim Final Rules dated 3-30-20 and 4-30-20 added the following additional services that will be paid for under the PCE:

- 99204, 99205, 99214, 99215
- 99441-99443 (telephone codes)
- 99421-99423 (MyChart codes)
- 99495-99496 (Transitional Care Management Services)
- 99452 (Interprofessional telephone/internet/EHR referral services- 30 minutes)
- G2012 and G2010 (virtual check-in and remote evaluation of recorded images)

**Teaching physicians will be able to bill for the following services of residents provided that the resident is under the direct supervision of the teaching physician through audio/video real time communications technology.**

- **Diagnostic radiology and other tests:** Interpretation of diagnostic radiology and other diagnostic tests performed. The TP must still review the resident’s interpretation.
- **Psychiatric Services :** psychiatric service in which a resident is involved
- **Quarantine situations:** If a resident is under quarantine but is otherwise able to furnish services that do not require face-to-face patient care, such as reading results of tests and imaging studies, Medicare will allow billing for teaching physician services if the resident is under direct supervision via virtual means.
- **Exception:** Surgeries, Endoscopies, and Anesthesia—Given the complex nature of these procedures and the potential danger to the patient, the supervision exceptions listed above **do not apply**.

**MOONLIGHTING:** Moonlighting residents will be able to bill provided that the resident is fully licensed to practice and the services are not performed as part of the approved GME program. This provision is mostly applicable to fellows.

**DIRECT GRADUATE MEDICAL EDUCATION (DGME)/INDIRECT MEDICAL EDUCATION (IME) (Added per Interim Revised Rule 4-30-20)**

- **IME payments due to increases in bed counts as a result of COVID-19 PHE:** Excludes beds temporarily added from the IME payment calculation during the PHE. The hospital’s available bed count from the day before the PHE was declared (1-31-20) will be used instead.
- **Time spent by Residents at another hospital during the COVID-19 PHE:** Teaching hospitals may claim time their residents spend training at the other hospital during the PHE. Requires either the sending or receiving hospital to be treating COVID-19 patients but does not require that the resident be involved in COVID-19 patient care activities.
- **Time spent by residents at alternative location during the COVID-19 PHE:** Allows hospitals to claim residents for DGME and IME purposes if hospitals continue to pay the resident's salary and fringe benefits for the time that the resident is at home or in a patient's home while performing duties within the scope of the approved residency program and meets appropriate physician supervision requirements.

**HEALTHCARE SERVICES AND FLEXIBILITIES PROVIDED DURING THE COVID-19 PHE**

**UCM specific guidance related to the scheduling, conduct, and documentation for telehealth services**

Send coding and billing questions to [Telemedicine.BillingQuestion@uchospitals.edu](mailto:Telemedicine.BillingQuestion@uchospitals.edu)

- COVID-19 EPIC Tip Sheets on the [UCM Intranet Page](#).
- [Provider Video Visit Set-up Guide](#) for Zoom patient visits
- [Provider Tip Sheet](#) for documenting a telehealth visit
- [OCC Pocket Guides and Provider Billing Tip Sheets](#)

**External Resources::**

- **CMS guidance:** [COVID-19 FAQs for FFS billing](#)
- **NGS guidance:** [COVID-19 FAQs for telehealth billing](#)
- [Interim Final Rule 3-31-20](#)
- [Interim Final Rule 4-30-20](#)
- **AAMC resources:** [COVID-19 website](#) and email [COF\\_COVID19@aamc.org](mailto:COF_COVID19@aamc.org)

**MEDICARE TELEHEALTH SERVICES DURING COVID-19 PUBLIC HEALTH EMERGENCY**

- **Originating Site Requirements:** Originating site and geographic restrictions for Medicare telehealth services have been lifted, allowing patients to receive telehealth services from any health care facility, as well as their home.
- **Distance Site Practitioner:** Distant site practitioners may furnish Medicare telehealth services from any location, including their home. Click [here](#) for CMS' MLN Booklet which describes telehealth services in more detail.
- **Types of Service:** Applicable services are those found on CMS' List of Telehealth Services even if unrelated to COVID-19. Click [here](#) for a list of these services.
  - ⇒ **Update 3-31-20: Interim Final Rule adds 80+ additional services to the telehealth list**
  - ⇒ **Update 4-30-20: Interim Final Rule adds 40+ new codes, including Telephone E/M services 99441-99443**
- **Technology:** Audio and video technology used for two-way, real-time interactive communication. This includes devices such as smart phones and i-pads and platforms such as Zoom (UCM preferred). Do not use public-facing platforms (such as Facebook Live).
  - ⇒ **Update 4-30-20: Interim Final Rule allows certain telehealth services to be provided via audio only.**
- **Removal of frequency limitations Medicare Telehealth :** The following services no longer have limitations on the number of times they can be provided by Medicare telehealth:
  - ◇ A subsequent inpatient visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every three days (CPT codes 99231-99233);
  - ◇ A subsequent skilled nursing facility visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every 30 days (CPT codes 99307-99310)
  - ◇ Critical care consult codes may be furnished to a Medicare beneficiary by telehealth beyond the once per day limitation (CPT codes G0508-G0509). **(Updated 3-31-20 Interim Final Rule)**
- **Using Time and MDM for outpatient E/M services (99201-99215) delivered via telehealth (e.g. Zoom video):** On an interim basis, CMS is revising its policy to specify that the office/outpatient E/M level selection for these services when furnished via telehealth can be based on medical decision making (MDM) or time, with time defined as all of the time associated with the E/M on the day of the encounter (attending time only). For purpose of level selection, use the times listed in the current CPT code descriptor. **(Updated 3-31-20 Interim Final Rule and clarified in 4-30-20 Interim Final Rule)**
- **Practitioners who may bill for telehealth services:**
  - \* Physician, Nurse practitioner (NP), Physician Assistant (PA), Nurse-midwives
  - \* Clinical nurse specialists (CNSs), Certified registered nurse anesthetists, and Registered dietitians or Nutrition professionals, may furnish telehealth services within their scope of practice and consistent with Medicare benefit rules that apply to all services.
  - \* All health care professionals that can furnish distant site telehealth services may bill Medicare for their professional services, including Physical therapists, occupational therapists, speech language pathologists and others. **(Updated 4-30-20 Interim Final Rule)**
  - \* Clinical psychologists (CPS) and clinical social workers (CSW) - CPs and CSWs cannot bill Medicare for psychiatric diagnostic interview exams with medical services or medical E/M services. They cannot bill or get paid for CPT codes 90792, 90833, 90836, and 90838.
  - \* Speech-language pathologists
- **Professional claims:** CMS will pay for professional claims for telehealth services for DOS starting on March 1, 2020 through the duration of the PHE. Bill with the Place of Service (POS) equal to what it would have been in the absence of a PHE, along with a modifier 95, indicating that the service rendered was actually performed via telehealth.
- **Hospital claims:** Hospital services associated with a Professional Claim for telehealth services may be billed to CMS if the service is furnished by a physician or practitioner who ordinarily practices in the HOPD to a registered outpatient of the hospital who is located at home or other applicable temporary expansion location that has been made provider based to the hospital. CMS will permit the hospital to bill and be paid the originating site facility fee amount for those telehealth services, just as they would have ordinarily done outside of the COVID-19 PHE in this circumstance. **(Updated 4-30-20 Interim Final Rule)**

**HEALTHCARE SERVICES AND FLEXIBILITIES PROVIDED DURING THE COVID-19 PHE**

Resources: [Interim Final Rule 3-31-20](#), AND [Interim Final Rule 4-30-20](#)

**TELEPHONE SERVICES**

- **Telephone Evaluation and Management Services (CPT 99441-99443) for Physicians and healthcare practitioners (NP and PA) that can directly bill for E/M services:** 99441 5-10 min , 99442 11-20 min, 99443 21-30 min  
 ⇒ **Update 4-30-20 Interim Final Rule:** Codes 99441-99443 have been added to Medicare Telehealth Services list for the duration of the COVID-19 PHE and payment has been increased. New valuations:  
     99441 (crosswalked to 99212): RVUs increased from 0.25 to 0.48  
     99442 (crosswalked to 99213): RVUs increased from 0.50 to 0.97  
     99443 (crosswalked to 99214): RVUs increased from 0.75 to 1.50
- **Telephone Assessment and Management Services for practitioners who cannot bill E/M services (LCSW, Clinical psychologist , Physical and occupational therapist, Speech language pathologist):** 98966 5-10 minutes, 98967 11-20 minutes, 98968 21-30 minutes
- **Limitations:** Service can bear no relation to an E/M service within the prior seven days, or result in an E/M service within the ensuing 24 hours (or soonest appointment).
- **Patient Type:** New or Established Patients—While the codes describe established patients, CMS will not be enforcing this part of the code description.
- **Modifiers:** Do not use Modifier 95 for 98966-98968 since this is not a telehealth code. POS is where the provider was located when conducting the service.

**Virtual Check-in Services**

- **G2012:** Patient initiated, brief (5-10 minutes) check-in initiated by established patient with the practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed.
- **G2010:** A remote evaluation of a recorded video and/or images submitted by an established patient
- **Billing Practitioner:** Physicians and other healthcare practitioners that can bil for E/M services, LCSW, Clinical psychologist, Physical and Occupational therapists, Speech-language pathologists
- **Modifiers:** Don't use Modifier 95 since this is not a telehealth code. POS is where the provider was located when conducting the service.
- **Frequency:** No limitations; CMS will monitor utilization.
- **Bundled E/M:** Service can bear no relation to an E/M service (in-person or telehealth visit) within the prior seven days, or result in an E/M service within the ensuing 24 hours (or soonest appointment).
- **Technology:** Telephone or other real-time, two-way audio communication; may be enhanced with video or other data transmission (excludes voice messages).
- **Patient Type:** New or Established Patients While the codes describe established patients, CMS will not be enforcing this part of the code description.
- **Consent:** patient must verbally consent (Medicare co-insurance and deductibles would apply). Annual consent documented by auxiliary staff is fine; the process should not interfere with provision of services.

**E-Visits**

- **Code Description:** Patient initiated Online digital E/M service for an established patient, up to 7 days, cumulative time during the 7 days
- **Codes for MD, NP, PA:** 99421: 5-10 min up to 7 days, 99422: 11-20 min up to 7 days, 99423: 21 or more min up to 7 days
- **Codes for Clinicians who cannot bill E/M service (LCSW, Clinical Psychologist, Physical and Occupational therapists, Speech-language pathologists):** G2061: 5-10 min up to 7 days, G2062: 11-20 min up to 7 days, G2063: 21 or more minutes up to 7 days
- **Frequency:** Services may only be reported once in a 7-day period. Clinical staff time may not be counted.
- **Bundled E/M Services:** If the patient had an E/M service within the last seven days, or has a face 2 face E/M visit related to the problem in the next 7 days, these codes may not be used.
- **Technology:** patient initiates service via electronic health record portal, secure email or other digital application. Follow-up by the provider may include telephone.
- **Patient Type:** \*New or Established Patients While the codes describe established patients, CMS will not be enforcing this part of the code description.
- **Consent:** patient must verbally consent (Medicare co-insurance and deductibles would apply)

**HEALTHCARE SERVICES AND FLEXIBILITIES PROVIDED DURING THE COVID-19 PHE**

Resources: [Interim Final Rule 3-31-20](#), AND [Interim Final Rule 4-30-20](#) AND [COVID-19 Regulations & Waivers To Enable Health System Expansion \(PDF\)](#) (5/4/20)

**RELOCATING PROVIDER BASED DEPARTMENTS TO NEW LOCATIONS (INCLUDING THE PATIENT'S HOME) (Added per Interim Final Rule 4-30-20)**

- **Description of Flexibility**  
On-campus provider based departments (PBDs) may relocate to off-campus locations (including the home of a patient who is registered as a hospital outpatient) during the COVID-19 PHE and begin furnishing and billing for services under the OPSS in the new location prior to submitting documentation to the Regional Office (RO) to support the extraordinary circumstances relocation request. These relocations must be consistent with the state's emergency preparedness and response plan.
- **Application Process**  
The hospital should notify their CMS Regional Office by email of their hospital's CCN; the address of the current PBD; the address (es) of the relocated PBD(s); the date which they began furnishing services at the new PBD(s); a brief justification for the relocation and the role of the relocation in the hospital's response to COVID-19; and an attestation that the relocation is not inconsistent with their state's emergency preparedness or pandemic plan. CMS expects hospitals to include in their justification for the relocation why the new PBD location (including instances where the relocation is to the patient's home) is appropriate for furnishing covered outpatient items and services.
- **Relocation Sites**  
Allows hospitals to relocate HOPDs to more than one off-campus location, or partially relocate off-campus while still furnishing care at the original site. Addresses hospitals that develop temporary expansion sites and repurpose existing clinical and non-clinical space for patient care.
- **Patient's Home**  
If a relocated PBD includes the patient's home, only one relocation request during the PHE is necessary. The hospital does not have to submit a unique request each time it registers a hospital outpatient for a PBD that is otherwise the patient's home; a single submission per location is sufficient. Hospitals must send this email to their CMS Regional Office within 120 days of beginning to furnish and bill for services at the relocated PBD.
- **Application Denied**  
If the relocation is denied by the RO, and the hospital did not bill for them using the PN modifier, any claims billed under the OPSS in the new location would need to be reprocessed as having been billed by a non-expected PBD and will instead be paid the PFS-equivalent rate.
- **Billing**  
Hospitals should append modifier "PO" to OPSS claims for services furnished at the relocated PBDs. This modifier indicates a service that is provided at an expected off-campus PBD and is paid the OPSS payment rate. Note: If the hospital does not seek an exception to relocate the PBD to the patient's home, the home would be considered a new non-expected off-campus PBD and the hospital would bill with the "PN" modifier and receive the PFS-equivalent rate.
- **Enrollment**  
If Medicare-certified hospitals will be rendering services in relocated expected PBDs, but intend to bill Medicare for the services under the main hospital, no additional provider enrollment actions are required (for example, hospitals do not need to submit an updated CMS-855A enrollment form) for the off-campus relocated site during the COVID-19 PHE.
- **Hospital Services that can be paid for when provided in the patient's home include**
  - ⇒ Telehealth Services provided by hospital-employed professional clinicians
  - ⇒ Hospital Outpatient and Therapy, Education, and Training Services
  - ⇒ Hospital-Based Partial Hospitalization Providers (PHP)
  - ⇒ Hospital In-Person Clinical Staff Services

# OCC COVID-19 COVERAGE AND PAYMENT GUIDANCE (Updated 11-12-20)

## HEALTHCARE SERVICES AND FLEXIBILITIES PROVIDED DURING THE COVID-19 PHE

Resources: [Interim Final Rule 3-31-30](#), AND [Interim Final Rule 4-30-30](#)

### Hospital Outpatient and Therapy, Education and Training Services performed at temporary expansion sites of a hospital (including the patient's home) - Added per the Interim Final Rule 4-30-20

- **Description of Services:** hospital outpatient therapy (including behavioral health), education, and training services that are furnished by hospital-employed counselors or other licensed professionals. Examples of these services include psychoanalysis, psychotherapy, diabetes self-management training, and medical nutrition therapy.
- **Change:** Outpatient therapy, education, and training services may be provided by the hospital to a patient in the hospital (including the patient's home if it is a PBD of the hospital) using telecommunications technology.
- **Effective Date:** March 1, 2020 and for the duration of the PHE
- **Technology:** audio and video technology should be used; however, if use of such technology is not possible, the service be furnished exclusively with audio.
- **Applicable Services:** See CMS' [List of Hospital Outpatient Services and List of Partial Hospitalization Program Services Accompanying the 4/30/2020 IFC \(ZIP\)](#)
- **Orders:** All services furnished by the hospital still require an order by a physician or qualified NPP and must be supervised by a physician or other NPP appropriate for supervising the service given their hospital admitting privileges, state licensing, and scope of practice.
- **Supervision:** General supervision is acceptable for a vast majority of hospital outpatient therapeutic services . This means a service must be furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the service.
- **Billing:** when services are furnished by hospital clinical staff within their scope of practice, the hospital should bill for these services as if they were furnished in the hospital and consistent with any specific requirements for billing Medicare during the COVID-19 PHE.

### Hospital-Based Partial Hospitalization Providers (PHP) performed at temporary expansion sites of a hospital (including the patient's home) - Added per the Interim Final Rule 4-30-20

- **Definition of PHP:** A PHP is an intensive outpatient program of psychiatric services provided as an alternative to inpatient psychiatric care for individuals who have an acute mental illness, which includes, but is not limited to, conditions such as depression and schizophrenia.
- **Effective Date:** March 1, 2020 and for duration of the PHE
- **Technology:** Video and audio; if both are not possible, audio only is allowed.
- **Applicable Services:** See CMS' [List of Hospital Outpatient Services and List of Partial Hospitalization Program Services Accompanying the 4/30/2020 IFC \(ZIP\)](#)
- **Order and Supervision:** all services furnished under the PHP still require an order by a physician, must be supervised by a physician, must be certified by a physician, and must be furnished in accordance with coding requirements by a clinical staff member working within his or her scope of practice.
- **Documentation:** documentation in the medical record of the reason for the visit and the substance of the visit is required.
- **Billing:** The hospital should bill for these services as if they were furnished in the hospital and consistent with any specific requirements for billing Medicare during the COVID-19 PHE

### Hospital In-Person Clinical Staff Services performed at temporary expansion sites of a hospital (including the patient's home) - Added per the Interim Final Rule 4-30-20

- **Description:** Services which require the hospital's clinical staff's presence to furnish the service, but do not require professional work by the physician or NPP. For example, wound care chemotherapy and other drug administration.
- **Change:** Such services may be provided by clinical staff in the patient's home as an outpatient PBD and the services may be billed and paid for as HOPD services when the patient is registered as a hospital outpatient.
- **Effective Date:** March 1, 2020 and for the duration of the PHE
- **Technology:** The nature of these services require the clinical staff to be present with the patient
- **Orders:** All services furnished by the hospital still require an order by a physician or qualified NPP and must be supervised by a physician or other NPP appropriate for supervising the service given their hospital admitting privileges, state licensing, and scope of practice.
- **Supervision:** General supervision is acceptable for most hospital outpatient therapeutic services . This means a service must be furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the service.
- **NSEDTS:** Services include non-surgical extended duration therapeutic services are services that can last a significant period of time, have substantial monitoring component that is typically performed by auxiliary personnel have a low risk of requiring the physician's or appropriate NPP's immediate availability after the initiation of the service, and are not primarily surgical in nature (usually direct supervision is required to initiate NSED, followed by general supervision, however, on 3-31-20, supervision was lowered to general throughout the service).
- **Billing:** when these services are furnished by hospital clinical staff within their scope of practice, the hospital should bill for these services as if they were furnished in the hospital and consistent with any specific requirements for billing Medicare during the COVID-19 PHE. Append PO modifier for excepted items and services and PN modifier for nonexcepted services.
- **Home Health Agency intersection:** To the extent that there is some overlap between the types of services a HHA and a HOPD can provide, and the patient has a current home health plan of care, the hospital should only furnish services that cannot be furnished by the HHA.

# OCC COVID-19 COVERAGE AND PAYMENT GUIDANCE (Updated 11-12-20)

## HEALTHCARE SERVICES AND FLEXIBILITIES PROVIDED DURING THE COVID-19 PHE

Resources: [Interim Final Rule 3-31-20](#), AND [Interim Final Rule 4-30-20](#)

### National Coverage or Local Coverage Determinations During the COVID-19 PHE

- **Face-to-face or in-person encounters in LCD/NCDs do not apply:** face-to-face or in-person encounters described in an LCD or NCD would not apply during the PHE (From the 3-30-20 Interim Final Rule)
- **Clinical Indications:** clinical indications within LCDs/NCDs for coverage across the following services will not be enforced during the PHE
  - \* Respiratory Related Devices
  - \* Oxygen and Oxygen Equipment
  - \* Home anticoagulation management
  - \* Infusion pump
  - \* Therapeutic Continuous Glucose Monitors . This is intended to permit COVID-19 patients to more closely monitor their glucose levels given that they are at risk for unpredictable impacts of the infection on their glucose levels and health. **(Added per Interim Final Rule 4-30-20)**
- **Reasonable and Necessary Requirements:** Some external stakeholders appear to be misinterpreting statements that CMS made in the March 31st IFC as waiving medical necessity requirements; CMS reminds providers that services must still be medically necessary in order to be paid under Part A or B. Accordingly, the medical record must be sufficient to support payment for the services billed (that is, the services were actually provided, were provided at the level billed, and were medically necessary). **(Clarified in the Interim Final Rule 4-30-20)**

### Payment for Remote Physiologic Monitoring (RPM) Services Furnished During the COVID-19 Public Health Emergency

- **Per Interim Final Rule 3-30-30,** Clinicians can provide remote patient monitoring services to both new and established patients. These services can be provided for both acute and chronic conditions and can now be provided for patients with only one disease. For example, remote patient monitoring can be used to monitor a patient’s oxygen saturation levels using pulse oximetry. (CPT codes 99091, 99457-99458, 99473- 99474, 99493-99494)
- **Update per Interim Final Rule 4-30-20**
  - \* CMS was notified by stakeholders that the RPM service described by CPT code 99454 cannot be reported for monitoring of fewer than 16 days during a 30-day period. CMS also observed that CPT codes 99091, 99453, 99457, and 99458, also have 30-day reporting periods. Stakeholders have alerted CMS that while it is possible that remote physiologic monitoring would be used to monitor a patient with COVID-19 for 16 or more days, many patients with COVID-19 who need monitoring do not need to be monitored for as many as 16 days.
  - \* **New Policy:** CMS is establishing a policy on an interim final basis for the duration of the COVID-19 PHE to allow RPM monitoring services to be reported to Medicare for periods of time that are fewer than 16 days of 30 days, but no less than 2 days, as long as the other requirements for billing the code are met.
  - \* **Payment:** Payment is unchanged. Payment for CPT codes 99454, 99453, 99091, 99457, and 99458 when monitoring lasts for fewer than 16 days of 30 days, but no less than 2 days, is limited to patients who have a suspected or confirmed diagnosis of COVID-19.

### End Stage Renal Disease

- Per Interim Final Rule 3-30-20, For Medicare patients with End Stage Renal Disease (ESRD), clinicians no longer must have one “hands on” visit per month for the current required clinical examination of the vascular access site. Additionally, CMS is exercising enforcement discretion regarding the requirement that patients receive a face-to-face visit monthly for the initial 3 months, and at least once every 3 months afterwards. This is so that clinicians provide the service via telehealth.

### In-person visits for Nursing Home Residents

- Per Interim Final Rule 3-30-20, CMS is waiving requirements for physicians and non-physician practitioners to perform in-person visits for nursing home resident and allow visits to be conducted as appropriate, via telehealth options.

### Care Planning for Home Health Services by NPs, CNSs, and PAs **(Added per Interim Final Rule 4-30-20)**

- A NP, CNS, and PA may now certify, establish and periodically review the plan of care, as well as supervise the provision of items and services for beneficiaries under the Medicare home health benefit. Such practitioners are also allowed to perform the face-to-face encounter for the patient for whom they are certifying eligibility; however, if a face-to-face encounter is performed by an allowed NPP, in an acute or post-acute facility, from which the patient was directly admitted to home health, the certifying practitioner may be different from the provider performing the face-to-face encounter. These regulation changes are retroactive to March 1 2020 and will become permanent and are not time limited to the period of the PHE for COVID-19.

**COVID-19 DIAGNOSIS CODING**

**Resources:**

- [ICD 10 Announcement 3-18-20](#)
- [MLN Special Edition 4-3-20 for U07.1](#)
- [MLN ICD-10 Update 4-1-20](#)
- [April 2020 Integrated Outpatient Code Editor \(I/OCE\) Specifications Version 21.1 R1](#)
- [Official ICD-10-CM Coding and Reporting Guidelines April 1, 2020 through September 30, 2020](#)

On March 18, 2020, [ICD-10-CM announced](#) that it would adopt the World Health Organization (WHO) code **U07.1 (COVID-19)**, effective **April 1, 2020**. Providers should use this new code, where appropriate, for discharge on or after April 1, 2020.

**1. COVID-19 Infections (Infections due to SARS-CoV-2)**

- A. Code only confirmed cases:** Code only a confirmed diagnosis of the 2019 novel coronavirus disease (COVID-19) as documented by the provider, documentation of a positive COVID-19 test result, or a presumptive positive COVID-19 test result. For a confirmed diagnosis, assign code U07.1, COVID-19. This is an exception to the hospital inpatient guideline Section II, H. In this context, “confirmation” does not require documentation of the type of test performed; the provider’s documentation that the individual has COVID-19 is sufficient. 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 COVID-19 is no longer required. If the provider documents “suspected,” “possible,” “probable,” or “inconclusive” COVID-19, do not assign code U07.1. Assign a code(s) explaining the reason for encounter (such as fever) or Z20.828, Contact with and (suspected) exposure to other viral communicable diseases.
- B. Sequencing of codes:** When COVID-19 meets the definition of principal diagnosis, code U07.1 should be sequenced first, followed by the appropriate codes for associated manifestations, except in the case of obstetrics patients as indicated in Section . I.C.15.s. for COVID-19 in pregnancy, childbirth, and the puerperium.
- C. Acute respiratory illness due to COVID-19**
- Pneumonia - assign codes U07.1 and J12.89, Other viral pneumonia.
  - Acute bronchitis- assign codes U07.1, and J20.8, Acute bronchitis due to other specified organisms. Bronchitis not otherwise specified (NOS) due to COVID-19 should be coded using code U07.1 and J40, Bronchitis, not specified as acute or chronic.
  - Lower respiratory infection- If the COVID-19 is documented as being associated with a lower respiratory infection, not otherwise specified (NOS), or an acute respiratory infection, NOS, codes U07.1 and J22, Unspecified acute lower respiratory infection, should be assigned. If the COVID-19 is documented as being associated with a respiratory infection, NOS, codes U07.1 and J98.8, Other specified respiratory disorders, should be assigned.
  - Acute respiratory distress syndrome- For acute respiratory distress syndrome (ARDS) due to COVID-19, assign codes U07.1, and J80, Acute respiratory distress syndrome.
- D. Exposure to COVID-19:** For cases where there is a concern about a possible exposure to COVID-19, but this is ruled out after evaluation, assign code Z03.818, Encounter for observation for suspected exposure to other biological agents ruled out. For cases where there is an actual exposure to someone who is confirmed or suspected (not ruled out) to have COVID-19, and the exposed individual either tests negative or the test results are unknown, assign code Z20.828, Contact with and (suspected) exposure to other viral communicable diseases. If the exposed individual tests positive for the COVID-19 virus, see guideline a).
- E. Screening for COVID-19:** For asymptomatic individuals who are being screened for COVID-19 and have no known exposure to the virus, and the test results are either unknown or negative, assign code Z11.59, Encounter for screening for other viral diseases. For individuals who are being screened due to a possible or actual exposure to COVID-19, see guideline d). If an asymptomatic individual is screened for COVID-19 and tests positive, see guideline g).
- F. Signs and symptoms without definitive diagnosis of COVID-19:** For patients presenting with any signs/symptoms associated with COVID-19 (such as fever, etc.) but a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms such as: R05 Cough , R06.02 Shortness of breath, R50.9 Fever, unspecified. If a patient with signs/symptoms associated with COVID-19 also has an actual or suspected contact with or exposure to someone who has COVID-19, assign Z20.828, Contact with and (suspected) exposure to other viral communicable diseases, as an additional code. This is an exception to guideline I.C.21.c.1, Contact/Exposure.
- G. Asymptomatic individuals who test positive for COVID-19:** For asymptomatic individuals who test positive for COVID-19, assign code U07.1, COVID-19. Although the individual is asymptomatic, the individual has tested positive and is considered to have the COVID-19 infection.



**COVID-19 SPECIMEN COLLECTION AND TEST CODES**

**Resources:**

- [AMA CPT Announcement](#) of new code
- [AMA Fact Sheet](#) for CPT Code 87635
- [MLN Special Edition G2023/G2024](#) 3-31-20
- [CMS Press Release for U0001](#) 2-13-20
- [CMS Press Release for U0002](#) 3-5-20
- [COVID-19 FAQ for FFS Billing](#)
- [CMS Ruling on U0003 and U0004](#) 4-14-20
- [NGS announcement on U0003 and U0004](#)
- [Interim Final Rule 4-30-20](#)
- [Price Transparency: Requirement to Post Cash Prices Online for COVID-19 Diagnostic Testing](#): The CARES Act requires providers of diagnostic tests for COVID-19 to post the cash price for such tests on their website from March 27 through the end of the PHE. For more information see the [FAQs](#).
- [IHA Update on COVID-19 Private Payer Guidance](#) IHA has created a [table](#) that summarizes COVID-19 coverage of testing/screening and treatment for health plans offered by health insurance issuers operating in Illinois.

**HCPCS Codes:** Medicare claims processing systems can accept these new codes starting 4-1-20 for dates of service on or after 2-4-20.

- **U0001** Released 2-6-20; applies to CDC's 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel Assay. For authorized CDC testing laboratories to test patients for SARS-CoV-2. NGS Payment Rate is \$35.91.
- **U0002:** Released 3-5-20; allows labs to bill for non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19). NGS Payment Rate is \$51.31

**AMA CPT Codes**

- **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 (Effective 3-13-20)
- **86328** 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 4-10-20)
- **86769** Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) (Effective 4-10-20)

**New Specimen Collection Codes for Independent Laboratories Billing for COVID-19 Testing:** Effective with line item date of service on or after March 1, 2020:

- **G2023** - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source
- **G2024** - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source

**CMS increases Medicare payment to \$100 for high-production Coronavirus lab tests. 4-14-20**

- **U0003:** Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R. (Effective 4/14/20)
- **U0004:** 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R. (Effective 4/14/20)

**Ordering of COVID-19 Diagnostic Tests and Influenza, and Respiratory Virus Tests (Added per Interim Final Rule 4-30-20)**

- COVID-19 tests may be covered when ordered by any healthcare professional authorized to do so under state law.
- Healthcare professionals may also order diagnostic laboratory test for influenza virus and respiratory syncytial virus but only when these tests are furnished in conjunction with a COVID-19 diagnostic laboratory test as medically necessary in the course of establishing or ruling out a COVID-19 diagnosis or identifying patients with an adaptive immune response to SARS-CoV-2 indicating recent or prior infection.
- Click [here](#) for CMS' list of applicable codes.

**CMS will pay for COVID-19 Serology Testing (Added per Interim Final Rule 4-30-20):** A blood-based serology test can be used to detect whether a patient may have previously been infected with the virus that causes COVID-19 by identifying whether the patient has antibodies specific to the SARS-CoV-2 virus. During the PHE, Medicare will cover FDA-authorized COVID-19 serology tests as they are reasonable and necessary for beneficiaries with known current or known prior COVID-19 infection or suspected current or suspected past COVID-19 infection. CMS is not aware of any professional society recommendations for confirmatory or repeat testing on the same sample. As such it expects to be billed once per sample. Further, CMS would not expect such tests to be performed and billed unless clinically indicated.

**Updated 5-19-2020- MAC COVID-19 Test Pricing:** Click [here](#) for payment rates for HCPCS Codes U0001, U0002, and CPT codes 87635, 86769, & 86328.

# OCC COVID-19 COVERAGE AND PAYMENT GUIDANCE (Updated 11-12-20)

## COVID-19 TEST CODES

### Resources:

- [AMA CPT Announcement](#) of new code
- [AMA Fact Sheet](#) for CPT Code 87635
- [MLN Special Edition G2023/G2024](#) 3-31-20
- [CMS Press Release for U0001](#) 2-13-20
- [CMS Press Release for U0002](#) 3-5-20
- [COVID-19 FAQ for FFS Billing](#)
- [CMS Ruling on U0003 and U0004](#) 4-14-20
- [NGS announcement on U0003 and U0004](#)
- [Interim Final Rule 4-30-20](#)
- [Price Transparency: Requirement to Post Cash Prices Online for COVID-19 Diagnostic Testing](#): The CARES Act requires providers of diagnostic tests for COVID-19 to post the cash price for such tests on their website from March 27 through the end of the PHE. For more information see the [FAQs](#).
- [IHA Update on COVID-19 Private Payer Guidance](#) IHA has created a [table](#) that summarizes COVID-19 coverage of testing/screening and treatment for health plans offered by health insurance issuers operating in Illinois.

### **Professional Practice Payment for COVID-19 specimen collection and assessment by clinical staff (Added per Interim Final Rule 4-30-20):**

- **Patient sees Clinical Staff only; no F2F with Physician/NPP:** During the PHE, Physicians and NPPs may use CPT code 99211 to bill for services furnished incident to their professional services, for both new and established patients when clinical staff assess symptoms and take specimens for COVID-19 laboratory testing. *NOTE: a physician or practitioner cannot bill for services provided by auxiliary clinical staff unless those staff meet all the requirements to furnish services "incident to" services. Under the interim final rule, direct supervision may be met through virtual presence of the supervising physician or practitioner using interactive audio and video technology for the duration of the PHE.*
- **Patient has face to face visit with Physician/NPP:** If the physician or NPP sees the patient face to face and collect specimens during an office/outpatient visit, the service would be considered bundled into payment for the visit (i.e., 99201-99205, 99212-99215) and 99211 would not be billed.
- **Payment Rate:** PFS pays a national unadjusted rate of \$23.46 for 99211. APC 5731 Level 1 Minor Procedures pays a national unadjusted rate of \$22.98.
- **Cost Sharing:** Because physicians and other practitioners will be using CPT code 99211, to conduct testing related visits, there will not be beneficiary cost sharing when the practitioner's office bills for this service, provided it results in an order for or administration of a COVID-19 test.

### **Hospital Outpatient Department Payment for COVID-19 specimen collection only using a new HCPCS code C9803 (Added per Interim Final Rule 4-30-20):**

- **New Code:** CMS created CPT code C9803 under the OPPS for HOPDs to bill for a clinic visit dedicated to specimen collection to help address the resource requirements hospitals face in establishing broad community diagnostic testing for COVID-19, including the specimen collection necessary to conduct the testing.
- **Code Description C9803** – "*Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), any specimen source*"
- **Limitations:** Cannot bill C9803 if there are other primary service is furnished in the same encounter, i.e., such as a emergency room or clinic visit, or observation or critical care services.
- **Cost-sharing:** there is no beneficiary cost-sharing for this code (coinsurance and deductible amounts) provided it results in an order for or administration of a COVID-19 test. CMS anticipates that a COVID-19 test will always be ordered or administered with HCPCS code C9803 because the descriptor for this code includes specimen collection for COVID-19.
- **Payment:** Assigned to APC 5731 Level 1 Minor Procedures which pays a national unadjusted rate of \$22.98.
- **Status Indicator:** CMS is assigning a status indicator of "Q1" to C9803 indicating that this service will be conditionally packaged under the OPPS when billed with a separately payable primary service in the same encounter. The OPPS will only make separate payment to a hospital when HCPCS code C9803 is billed without another primary covered hospital outpatient service. The OPPS also will make separate payment for CPT code C9803 when it is billed with a clinical diagnostic laboratory test with a status indicator of "A" on Addendum B of the OPPS.

### **Flexibility for Medicaid Laboratory Services (Added per Interim Final Rule 4-30-20):**

- Medicaid coverage is available for laboratory tests and X-ray services that do not meet conditions specified in § 440.30(a) or (b) so long as the purpose of the laboratory or X-ray service is to diagnose or detect SARS-CoV-2, antibodies to SARS-CoV-2, COVID-19, or the communicable disease named in the PHE or its causes, and so long as the deviation from the conditions specified in § 440.30(a) or (b) is intended to avoid transmission of the communicable disease.
- Medicaid coverage is available for laboratory processing of self-collected laboratory test systems that the FDA has authorized for home use, if available to diagnose or detect SARS-CoV-2, antibodies to SARS-CoV-2, COVID-19, or the communicable disease named in the PHE or its causes, even if those self-collected tests would not otherwise meet the requirements in § 440.30(a) or (b).
- States are permitted to cover laboratory processing of self-collected test systems that the FDA has authorized for home use, without the order of a treating physician or other licensed non-physician practitioner (NPP).
- Laboratories that process such test systems without an order, as permitted under this new § 440.30(d), must notify the patient and the patient's physician or NPP, if known by the laboratory, of the results.

**COST-SHARING OF COVID-19 TESTS AND SERVICES**

**Resources:**

- [MLN Special Edition Article Tuesday, April 7, 2020](#)
- [4/11/20 FAQs about the FFCRA and CARES Act](#)
- [OIG Policy Statement about Cost Sharing](#)
- [OIG FAQ about Cost Sharing](#)
- [Interim Final Rule 4-30-20](#)
- [Families First Coronavirus Response Act \(H.R. 6201\)](#)

**Coverage of COVID-19 Test Services** The Families First Coronavirus Response Act (H.R. 6201) was signed into law on March 18, 2020. Group health plans and health insurance issuers offering group or individual health insurance coverage are required to cover, at no cost to the patient, the COVID-19 diagnostic test. They would also be required to cover the patient’s visit to a provider, urgent care center or emergency room to receive the testing. **“Group health plan”** includes both insured and self-insured group health plans, private employment-based group health plans (ERISA plans), non-federal governmental plans (such as plans sponsored by states and local governments), and church plans. **“Individual health insurance coverage”** includes coverages offered in the individual market through or outside of an exchange, as well as student health insurance coverage.

**The MLN Special Edition Article from 4-7-20, describes the coverage in more detail:** These services are medical visits for the HCPCS evaluation and management categories described below when an outpatient provider, physician, or other providers and suppliers that bill Medicare for Part B services orders or administers COVID-19 lab test U0001, U0002, or 87635.

Cost-sharing does not apply for COVID-19 testing-related services, which are medical visits that: are furnished between March 18, 2020 and the end of the Public Health Emergency (PHE); that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test; and are in any of the following categories of HCPCS evaluation and management codes:

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

Cost-sharing does not apply to the above medical visit services for which payment is made to:

- 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)

**CS Modifier:** For services furnished on March 18, 2020, and through the end of the PHE, outpatient providers, physicians, and other providers and suppliers that bill Medicare for Part B services under these payment systems should use the **CS modifier** on applicable claim lines to identify the service as subject to the cost-sharing waiver for COVID-19 testing-related services and should NOT charge Medicare patients any co-insurance and/or deductible amounts for those services. For professional claims, physicians and practitioners who did not initially submit claims with the CS modifier must notify their Medicare Administrative Contractor (MAC) and request to re-submit applicable claims with dates of service on or after 3/18/2020 with the CS modifier to get 100% payment. For institutional claims, providers, including hospitals, CAHs, RHCs, and FQHCs, who did not initially submit claims with the CS modifier must resubmit applicable claims submitted on or after 3/18/2020, with the CS modifier to visit lines to get 100% payment.

**OIG Policy Statement on Cost-Sharing Reductions or Waivers:** On March 17, 2020, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) released a [Policy Statement](#) that it would not impose administrative sanctions on physicians or other practitioners who reduce or waive cost-sharing for Federal health care program beneficiaries for telehealth services furnished during the COVID-19 public health emergency, which has existed since January 27, 2020. OIG’s [FAQ](#) clarifies that the policy applies to a broad category of non-face-to-face services furnished through various modalities, including telehealth visits, virtual check-in services, e-visits, monthly remote care management, and monthly remote patient monitoring.

COVERAGE OF TELEHEALTH SERVICES BY ILLINOIS DEPARTMENT OF HEALTH AND FAMILY SERVICES

Resources:

- [FAQs for Illinois Medicaid Virtual Healthcare Expansion/Telehealth](#)
- [HFS Provider Memo dated 3/30/20](#)
- [COVID-19 Virtual Healthcare Expansion Billing Codes– posted 4-1-20](#)

**Telehealth Services Under the Public Health Emergency (PHE):** To protect the public health in connection with the PHE, HFS will reimburse medically necessary and clinically appropriate telehealth and as well as services that do not meet the definition of telehealth (virtual check-in, E-visit, behavioral health services) with DOS on or after March 9, 2020 until the PHE no longer exists. What has changed:

- No longer need an existing relationship for telehealth visits.
- Expansion of distant site providers includes MD, PA, APN, LCP, LCSW and Physical, Speech and Occupational therapist (click [here](#) for complete list)
- Payment for non-telehealth services (e.g., Virtual Check-in, E-visits, Behavioral health)
- Members can receive services at a wider range of facilities (“originating sites”), including their home
- While audio-visual means of communication are preferred (i.e., Zoom, face-time, etc.) audio-only telephone calls may be reimbursed when there is enough information to meet the requirements of the service when rendered via face-to-face interaction.

**Reimbursement:** Telehealth payment rates are the same as face-to-face services provided on-site. [Reimbursement Schedule](#) and [COVID-19 Virtual Care Schedule](#)

**Originating Sites (Updated 3/30/20):**

- **Valid Sites:** The 3/20/20 notice contained a list of valid originating sites, **including a patient’s place of residence** located within the state of Illinois or other temporary location within or outside the state of Illinois.
- **Originating Site \$25.00 facility fee:** Certified eligible facilities or provider organizations that act as the location for the patient when the telehealth service is rendered are eligible for a facility fee. **Note– if the participant receives services at home or a temporary residence, there is no billable originating site service.**
  - ◊ **Hospital instructions:** Hospitals are already able to bill as a non-institutional provider originating site as stated in the [Handbook for Practitioner Services](#), topic 202.1.4.
  - ◊ **All other originating Facility Sites–** HFS is working on a payment system.

**Distant Site (Updated 3/30/20):**

- **Valid Distant Site:** The distant site provider is any enrolled provider, operating within their scope of practice, and with the appropriate license or certification.
- POS 02 and Modifier GT:** The 3/30/20 Notice clarifies that all distant site providers billing for telehealth services, regardless of where they are providing the telehealth service (including from their own home), must use modifier GT and POS 02 on their claims.

**NEW 3/30/20—Telehealth Consultation Codes:** For physicians providing consultation to inpatients, the following time-based codes have been opened for distant site providers effective with DOS on or after March 9, 2020. Must be billed with Modifier GT and POS 02.

- ⇒ G0406 (15 min), G407 (25 min), G0408 (35 min): F/U inpatient consult via telehealth
- ⇒ G0425 (30 min), G0426 (50 min), G0427 (70 min): Telehealth consult, ED or initial inpatient

**E/M Services:** E/M services rendered by Physicians, APNs, and PA to new or existing patients using audio only telephonic equipment may be billed as a distant site telehealth service so long as the E/M services is of an amount and nature that would be sufficient to meet the key components of a face-to-face encounter. The claim must be submitted with POS 02 and Modifier GT. If an audio only encounter cannot meet the key components, consider billing Virtual Check-in Code G2012.

**Billing for Non-Telehealth Services**

- **Virtual Check-in (Updated 3/30/20)** – These are brief (5-10 minute) communications (via telephone or other communication devices) to determine if an additional service is needed. Bill with HCPCS codes G2012 and G2010. (Note– this is a change from the 3/20/20 Notice which specified that providers should use CPT codes 99441-99443). Include modifier GT and POS 02. Billable by Physicians, PAs, APNs.
- **Online patient portal or “E-visit” (Updated 3/30/20)** : These are communications initiated by the patient via an on-line portal. HFS will reimburse for HCPCS codes G2061-2063 and CPT codes 99421-99423. Include modifier GT and POS 02. Billable by Physicians, PAs, APNs.
- **Behavioral health services:** HFS will reimburse for all behavioral health services detailed in [140.453](#) (except for Mobile Crisis Response and Crisis Stabilization as defined in [140.453\(d\)\(3\)](#)) and behavioral health services contained on an applicable Department fee schedule provided using [audio-only real-time telephone interactions, or video interaction.](#) Billing providers include Physicians, APNs, PAs. Include modifier GT and POS 02.

**COVERAGE OF SERVICES BY NON-MEDICARE PAYORS**

**[Aetna Coverage \(content updated 4/30/20\)](#)**

**COVID-19 testing (4/30/20):** Aetna is waiving co-pays and applying no cost-sharing for all diagnostic testing related to COVID-19, including serologic antibody testing. This policy will cover the cost of a physician-ordered test and the physician visit that results in the order or administration of a COVID-19 test, which can be done in any approved laboratory location. Aetna will waive the member costs associated with diagnostic testing for all Commercial, Medicare and Medicaid lines of business. The policy aligns with new Families First legislation requiring all health plans to provide full coverage of COVID-19 testing without cost share. The requirement also applies to self-insured plans.

**For the next 90 days, until June 4, 2020, Aetna will waive member cost sharing for any covered telemedicine visits – regardless of diagnosis—for Commercial plans (4/30/20):** Cost sharing will be waived for all virtual visits through the Aetna-covered Teladoc® offerings and in-network providers. Self-insured plan sponsors will be able to opt-out of this program at their discretion. **No cost sharing until further notice for Medicare Advantage.**

**Aetna is also offering its Medicare Advantage brief virtual check-in and remote evaluation benefits to all Aetna Commercial members and waiving the co-pay:** These offerings will empower members with questions or concerns that are unrelated to a recent office visit and do not need immediate in-person follow-up care to engage with providers without the concern of sitting in a physician’s office and risking potential exposure to COVID-19.

**Telehealth (4/30/20):** Through June 4, 2020 Aetna will cover minor acute evaluation and management services care services rendered via telephone. A visual connection is not required. For general medicine and behavioral health visits – a synchronous audiovisual connection is still required.

**[Cigna Coverage \(link and content updated 4/30/20\)](#)**

**COVID-19 diagnostic visits (4/30/20):** Cigna is waiving out-of-pocket costs for COVID-19 visits with in-network providers, whether at a provider’s office, urgent care center, emergency room, or via virtual care, effective March 2nd through May 31, 2020.

**COVID-19 testing (4/30/20):** Cigna is waiving out-of-pocket costs for COVID-19 FDA-approved testing including antibody testing. Only a health care provider or hospital can administer the test and send the sample to an approved lab for results.

**COVID-19 treatment:** Your plan will cover treatment associated with COVID-19 or similar diseases. Out-of-pocket costs may apply.

**COVID-19 Virtual Care Visits:** For a virtual visit related to screening, diagnosis, or testing for COVID-19, out-of-pocket costs will be waived.

**Non-COVID-19 Virtual Care Visits (4/30/20):** Members can also receive virtual medical care not related to COVID-19 by physicians and certain providers with virtual care capabilities through May 31, 2020. Out-of-pocket costs may apply. **Services can be performed by phone, video, or both.**

**[BlueCross BlueShield of Illinois Coverage](#)**

**[\(link and content updated 3/23/20\)](#)**

**COVID-19 Testing (4/30/20):** Effective March 19th, Members won't pay copays, deductibles or coinsurance for testing to diagnose COVID-19 or for testing-related visits with in-network providers, whether at a provider's office, urgent care clinic, emergency room or by telehealth.

**Telehealth:** Members can access provider visits for covered services through telemedicine or telehealth as outlined in their benefit plan or employer’s self-funded plan. Members won’t pay copays, deductibles, or coinsurance on in-network covered telemedicine or telehealth services. Depending on their benefits, members may have access to services through two-way, live interactive telephone and/or digital video consultations, and virtual visits powered by MDLIVE.

**COVERAGE OF SERVICES BY NON-MEDICARE PAYORS**

**[Humana \(link and content updated 4/30/20\)](#)**

**COVID-19 testing (4/30/20):** Cost-share waivers include COVID-19 related testing (COVID-19 test and viral panels that rule out COVID-19); laboratory testing, specimen collection and certain related services that result in the ordering or administration of the test, including physician office or emergency department visits. This change is retroactive to services delivered on or after Feb. 4, 2020.

**Temporary expansion of telehealth service scope and reimbursement rules:**

1. Humana encourages use of telehealth services to care for members. Refer to CMS, state, and plan coverage guidelines for services that can be delivered via telehealth.
2. Humana will temporarily reimburse for telehealth visits with participating/in-network providers at the same rate as in-office visits assuming they meet medical necessity criteria and all applicable coverage guidelines
3. Humana will temporarily accept telephone (audio-only) visits for providers/members who don't have access to secure video systems. They can be submitted and reimbursed as telehealth visits.
4. Humana is waiving cost share for all telehealth services delivered by participating/in-network providers; this includes
  - Visits through audio or video
  - Visits through MDLive to Medicare Advantage members, and Commercial members in Puerto Rico
  - All telehealth services through Doctor on Demand to Commercial members

**[United Healthcare \(link and content updated 4/30/20\)](#)**

**COVID-19 testing (4/30/20):** United Healthcare is waiving cost sharing for COVID-19 testing and related visits, whether the testing related visits is received in a health care provider's office, an urgent care center, an emergency department or through a telehealth visit. This coverage applies to Medicare Advantage, Medicaid and employer-sponsored plans. **Effective Feb 4th and throughout the national emergency.**

**Telehealth resources (4/30/20):**

1. **24/7 Virtual Visits through designated telehealth providers:** These visits can be useful in determining if a member should call their local health care provider regarding COVID-19 testing, and are also ideal for urgent care treatment of other illnesses, like the seasonal flu, allergies, pink eye and more. Medicare Advantage and Medicaid members can continue to access their existing telehealth benefit offered through designated partners without cost sharing. Effective March 18th, cost sharing for members with a telehealth benefit through their employer-sponsored plan will be waived through June 18, 2020.
2. **Eligible care providers can bill for telehealth services performed using interactive audio-video or audio-only, except in the cases where UHC explicitly denotes the need for interactive audio/video.**
3. **Local telehealth visits with your medical provider:** Telehealth visits with a member's health care provider can be used for both COVID-19 and other health needs. For COVID-19 testing related telehealth visits with a health care provider, cost-sharing is waived during this national emergency. For other health related telehealth visits, cost sharing and coverage will apply as determined by the members health benefits plan, through June 18, 2020.