**OCC COVID-19 COVERAGE AND PAYMENT GUIDANCE (Updated 4-23-20)**

**DISCLAIMER:** This document is intended to provide a consolidated update on the rapidly shifting changes in regulatory requirements related to COVID-19. Guidance on specific patient care or documentation and billing/coding workflows being implemented at UCM are separate and 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.

<table>
<thead>
<tr>
<th>TABLE OF CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS Blanket Waivers</td>
</tr>
<tr>
<td>MIPS Changes</td>
</tr>
<tr>
<td>Accelerated Payments</td>
</tr>
<tr>
<td>Medicare Appeals</td>
</tr>
<tr>
<td>Cost Reporting</td>
</tr>
<tr>
<td>Open Payments</td>
</tr>
<tr>
<td>Beneficiary Notice Delivery</td>
</tr>
</tbody>
</table>

**UPDATES SINCE 4/21/20**

- **Reminder to submit MIPS data by 4/30/20:** Data submission for MIPS clinicians is due by 4/30/20. Those who are not able to submit any MIPS data by April 30, 2020 will qualify for the automatic extreme and uncontrollable circumstances policy and receive a neutral payment adjustment for the 2021 MIPS payment year. MIPS eligible clinicians, groups, and virtual groups, including those not able to complete their 2019 MIPS data submission, can still apply for a 2019 extreme and uncontrollable circumstances exception. Applications can be submitted until 8:00 p.m. ET on April 30, 2020. Review the Quality Payment Program COVID-19 Response Fact Sheet for more information on these added flexibilities.

- **Allocation of CARES Act $50 billion Provider Relief Fund for general allocation to Medicare facilities and providers:** Distribution of these funds began on April 10. Providers who receive funds have to sign an attestation confirming receipt of funds and agree to the terms and conditions of payment and confirm the CMS cost report. For details about CARES Act funds, go to HHS.gov site.

- **Allocation of CARES Act funds for COVID-19 high impact areas ($10 billion)—Deadline for Hospitals extended to 4/25/20:** In an email sent on Tuesday, April 21, HHS announced hospitals must report certain data as a pre-requisite for payment for certain CARES Act funds. The deadline has been extended from before midnight on 4/23/20 to 12 p.m. Pacific Time on Saturday, 4/25/20. See IHA’s memo for details a well as the HHS.gov site.

- **Allocation of CARES Act funds for treatment of the uninsured—Sign-up period begins April 27:** Every health care provider who has provided treatment for uninsured COVID-19 patients on or after February 4, 2020, can request claims reimbursement through the program and will be reimbursed at Medicare rates, subject to available funding. Steps will involve: enrolling as a provider participant, checking patient eligibility, submitting patient information, submitting claims, and receiving payment via direct deposit. Go to https://www.hrsa.gov/coviduninsuredclaim for details.

- **Weighting factor of the assigned DRG increased by 20% for patients diagnosed with COVID-19:** The CARES Act directs the Secretary to increase the weighting factor of the assigned DRG by 20 percent for an individual diagnosed with COVID-19 discharged during the COVID-19 PHE. Discharges of an individual diagnosed with COVID-19 will be identified by the presence of the ICD-10-CM diagnosis codes listed below. For further details, click here for the related MLN Matters Article.
  - B97.29 (Other coronavirus as the cause of diseases classified elsewhere) for discharges occurring on or after January 27, 2020, and on or before March 31, 2020.
  - U07.1 (COVID-19) for discharges occurring on or after April 1, 2020 through the duration of the COVID-19 public health emergency period.

- **Updated Guidance for to issuers of individual, small group, Medicare Advantage, and Part D plans during COVID-19:** For details, go to Individual and Small Group Plan Guidance and Medicare Advantage and Part D Plan Guidance.

- **AMA** announces two code to report when patients receive blood tests that detect COVID-19 antibodies—CPT 86328 and CPT 86769. Click here for details.

- **For all CMS updates:** CMS News Room and Current Emergencies Website. For AAMC Resources: COVID-19 website; email COF_COVID19@aamc.org
April 9, 2020: CMS suspended additional rules which affect rural hospitals, skilled nursing facilities, home health agencies, and hospices. For details, review the Press Release and updated list of Emergency Blanket Waivers.

- **EMTALA:** Hospitals may screen patients at a location offsite from the hospital’s campus to prevent the spread of COVID-19, if it is not inconsistent with a state’s emergency preparedness or pandemic plan.

- **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 Policies 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.

- **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 license 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.
ADDITIONAL CMS FLEXIBILITIES DURING THE PHE

National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) on Respiratory Related Devices, Oxygen and Oxygen Equipment, Home Infusion Pumps and Home Anticoagulation Therapy: To provide clinicians with maximum flexibility, current NCDs and LCDs that restrict coverage of these devices and services to patients with certain clinical characteristics do not apply during the public health emergency. For example, Medicare will cover non-invasive ventilators, respiratory assist devices and continuous positive airway pressure devices based on the clinician’s assessment of the patient.

Changes to 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 registry 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.

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.

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

Medicare Appeals for Fee for Service, Medicare Advantage and Part D: CMS is allowing MACs and QIOs to allow extensions to file an appeal and waiver of timelines for requests for additional information to adjudicate the appeal.

Cost Reporting: CMS is delaying the filing deadline of certain cost report due dates due to the COVID-19 outbreak. We are 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.

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.

Resources
• Coronavirus Waivers & Flexibilities
• Coronavirus Clinical and Technical Guidance
• Teaching Hospital Flexibilities
• Physician and Other Clinician Flexibilities
• COVID-19 Blanket Waivers for Healthcare Providers
• Interim Final Rule released March 30, 2020
• 4/9/20 Updated FAQs COVID-19 FFS Billing
• CMS Video published 3-30-20 on Medicare Coverage and Payment of Virtual Services
• Dear Clinician Letter published 4-7-20
• 4/11/20 FAQs about the FFCRA and CARES Act

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.

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For details of all affected quality reporting programs, see CMS’ Press Release dated March 22, 2020.
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 dated March 20, 2020.

- HFS Memorandum 4/1/20 COVID-19 Telehealth Update #1: 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. Changes are effective beginning March 1, 2020, until the termination date of the public health emergency, including any extensions. Highlights include:
  - Removal of prior authorization for physical, occupational, and speech therapies, and home health
  - Waiver of face-to-face encounter requirements for ordering DME, Home health, and therapy
ILNOIS Department of Healthcare and Family Services (HFS) Telehealth Coverage Details (updated per HFS Provider Memo dated 3/30/20)

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. The 3/30/20 Notice clarifies that Family Support Program residential providers, Medically Complex Facilities for Persons with Developmental Disabilities, and Specialized Mental Health Rehabilitation Facilities are included as a site.

- 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), G0407 (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.

Resources:
COVID-19 testing: Aetna is waiving co-pays and applying no cost-sharing for all diagnostic testing related to COVID-19. This policy will cover the cost of a physician-ordered test and the physician visit that results in 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: 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.

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.

COVID-19 Testing: 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.

COVID-19 diagnostic visits: 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, through May 31, 2020.

COVID-19 testing: Cigna is waiving out-of-pocket costs for COVID-19 FDA-approved 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: 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.
COVID-19 testing. 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 March 6, 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 (content updated 3/23/20)

COVID-19 testing: 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.

Telehealth resources:

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. Cost sharing for members with a telehealth benefit through their employer-sponsored plan will be waived through June 18, 2020.
2. 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.
TEACHING PHYSICIAN (TP) REGULATIONS

1. Presence and Participation during the E/M service: For both inpatient and outpatient E/M services, the requirement of physical presence of the TP during the key or critical part of the service can be met if the TP is present with the resident via real time audio and video communication during the key and critical portions of the service, as determined by the TP.

2. 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 virtual means:

- **Primary Care Exception:** All levels of an office/outpatient E/M service under the Primary Care Exception provided in primary care centers.
- **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
- **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. CMS has asked for comments on this.

**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.

**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.

Resources:
- [Teaching Hospital Flexibilities](#)
- [Interim Final Rule released March 30, 2020](#)
COVID-19 DIAGNOSIS CODING

On March 18, 2020, [ICD-10-CM announced](https://www.cms.gov/Medicare/Coding/Codes/Announcements) that it would adopt the World Health Organization (WHO) code [U07.1 (COVID-19), effective April 1](https://www.cdc.gov/coronavirus/2019-ncov/community/diagnosis/coding.html). Providers should use this new code, where appropriate, for discharge on or after April 1, 2020.

**Confirmed Cases of COVID-19**
- Code U07.1 as the primary code
- Pneumonia and all other manifestations should also be coded.

**Concern about exposure to COVID-19**
For cases where there is concern about a possible exposure to COVID-19, but this is ruled out after evaluation,” report code [Z03.818](https://www.cms.gov/Medicare/Coding/Codes/Announcements) (Encounter for observation for suspected exposure to other biological agents ruled out), the CDC instructs.

**Actual exposure to a confirmed case of COVID-19**
Report code [Z20.828](https://www.cms.gov/Medicare/Coding/Codes/Announcements) (Contact with and [suspected] exposure to other viral communicable diseases).

**Signs/symptoms**
When the patient is exhibiting signs and symptoms but a definitive diagnosis has not been established, the CDC instructs that you code only the presenting signs and symptoms, such as:
- **R05** (Cough),
- **R06.02** (Shortness of breath) or
- **R50.9** (Fever, unspecified).

**Resources:**
- [ICD 10 Announcement 3-18-20](https://www.cms.gov/Medicare/Coding/Codes/Announcements)
- [MLN Special Edition 4-3-20 for U07.1](https://www.cms.gov/Medicare/Coding/Codes/Announcements)
- [MLN ICD-10 Update 4-1-20](https://www.cms.gov/Medicare/Coding/Codes/Announcements)
- [April 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.1 R1](https://www.cms.gov/Medicare/Coding/Codes/Announcements)

COVID-19 TEST CODES

**Medicare 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.
- **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.

**Resources:**
- [AMA CPT Announcement](https://www.cms.gov/Medicare/Coding/Codes/Announcements) of new code
- [AMA Fact Sheet](https://www.cms.gov/Medicare/Coding/Codes/Announcements) for CPT Code 87635
- [MLN Special Edition G2023/G2024](https://www.cms.gov/Medicare/Coding/Codes/Announcements)
- [COVID-19 FAQ for FFS Billing](https://www.cms.gov/Medicare/Coding/Codes/Announcements)
- [CMS Ruling on U0003 and U0004](https://www.cms.gov/Medicare/Coding/Codes/Announcements) 4-14-20
- [NGS announcement on U0003 and U0004](https://www.cms.gov/Medicare/Coding/Codes/Announcements)
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)

COVERAGE OF COVID-19 TESTS

- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)

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 resubmit 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.

Review the 4/11/20 FAQs about the FFCRA and CARESE Act for more details regarding the types of tests and services that must be covered.

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.

Resources:

- MLN Special Edition Article Tuesday, April 7, 2020
- 4/11/20 FAQs about the FFCRA and CARESE Act
OCC COVID-19 COVERAGE AND PAYMENT GUIDANCE (Updated 4-23-20)

Provider Tip Sheets for conducting, documenting and coding of telehealth and telemedicine visits

For UCMC specific guidance related to the scheduling, conduct, and documentation for telehealth services, consult the following resources:
- Send coding and billing questions to Telemedicine.BillingQuestions@ucchospitals.edu
- COVID-19 EPIC Tip Sheets on the UCMC Intranet Page.
- Provider Video Visit Set-up Guide for Zoom patient visits
- Provider Tip Sheet for documenting a telehealth visit

CMS guidance: COVID-19 FAQs for FFS billing
NGS guidance: COVID-19 FAQs for telehealth billing
AAMC resources: COVID-19 website and email COF_COVID19@aamc.org

Description of Additional Services Permitted by CMS during Public Health Emergency (PHE) (Updated 3-30-20)

Practitioners who may bill for services (Updated 3-30-20)

Permitted Technology
- Audio and video technology used for two-way, real-time interactive communication
- This includes smart phones, Zoom (UCMC preferred), or Face time*
- Cannot be public facing (such as Facebook Live).

Medicare Telehealth Visits

- **Expansion of Telehealth Services**: During the PHE, 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. Additionally, the distant site practitioner may furnish Medicare telehealth services from their home / Click here for CMS’ MLN Booklet which describes telehealth services in more detail.

- **Types of Service**: Patients may receive any of the services on CMS’ List of Telehealth Services even if unrelated to COVID-19, as well another 80+ services added with the Interim Final Rule published on 3-30-20. Click here for a list of these services.

- **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).

- **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).

- **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.

- Physician
- Nurse practitioner (NP)
- Physician Assistant (PA)
- Nurse-midwives
- Other practitioners, such as
  - Clinical nurse specialists (CNSs)
  - Certified registered nurse anesthetists, and
  - Registered dieticians or Nutrition professionals may furnish telehealth services within their scope of practice and consistent with Medicare benefit rules that apply to all services.

- 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.
## OCC COVID-19 COVERAGE AND PAYMENT GUIDANCE (Updated 4-23-20)

**Description of Additional Services Permitted by CMS during Public Health Emergency (PHE) (Updated 3-30-20)**

<table>
<thead>
<tr>
<th>Virtual Check-in Visits (Telemedicine service)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- <strong>G2012</strong>: 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.</td>
</tr>
<tr>
<td>- <strong>G2010</strong>: A remote evaluation of a recorded video and/or images submitted by an established patient.</td>
</tr>
<tr>
<td>- <strong>Frequency</strong>: No limitations; CMS will monitor utilization.</td>
</tr>
<tr>
<td>- <strong>Bundled E/M</strong>: 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).</td>
</tr>
<tr>
<td>- <strong>Patient Type</strong>: New or Established Patients While the codes describe established patients, CMS will not be enforcing this part of the code description.</td>
</tr>
<tr>
<td>- <strong>Consent</strong>: 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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practitioners who may bill these services (Updated 3-3-20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- <strong>Physician and other healthcare practitioners</strong> (NP and PA) that can directly bill for E/M services.</td>
</tr>
<tr>
<td>- <strong>Licensed clinical social workers</strong></td>
</tr>
<tr>
<td>- <strong>Clinical social workers</strong></td>
</tr>
<tr>
<td>- <strong>Physical and Occupational therapists</strong></td>
</tr>
<tr>
<td>- <strong>Speech-language pathologists</strong></td>
</tr>
<tr>
<td>- Do not use Modifier 95 since this is not a telehealth code. POS is where the provider was located when conducting the service.</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Permitted Technology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone or other real-time, two-way audio communication; may be enhanced with video or other data transmission (excludes voice messages).</td>
</tr>
</tbody>
</table>

**E-Visits (Telemedicine service)**

<table>
<thead>
<tr>
<th>Patient initiated Online digital E/M service for an established patient, up to 7 days, cumulative time during the 7 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>- <strong>Codes for MD, NP, PA:</strong></td>
</tr>
<tr>
<td>- 99421: 5-10 min up to 7 days,</td>
</tr>
<tr>
<td>- 99422: 11-20 min up to 7 days,</td>
</tr>
<tr>
<td>- 99423: 21 or more min up to 7 days</td>
</tr>
<tr>
<td>- <strong>Codes for other practitioners who cannot bill E/M service:</strong></td>
</tr>
<tr>
<td>- G2061: 5-10 min up to 7 days,</td>
</tr>
<tr>
<td>- G2062: 11-20 min up to 7 days,</td>
</tr>
<tr>
<td>- G2063: 21 or more minutes up to 7 days</td>
</tr>
<tr>
<td>- <strong>Frequency</strong>: Services may only be reported once in a 7-day period. Clinical staff time may not be counted.</td>
</tr>
<tr>
<td>- <strong>Bundled E/M Services</strong>: 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.</td>
</tr>
<tr>
<td>- <strong>Patient Type</strong>: <em>New or Established Patients</em> While the codes describe established patients, CMS will not be enforcing this part of the code description.</td>
</tr>
<tr>
<td>- <strong>Consent</strong>: patient must verbally consent (Medicare co-insurance and deductibles would apply)</td>
</tr>
<tr>
<td>- <strong>Physicians and healthcare practitioners</strong> (NP and PA) that can directly bill for E/M services use 99421-99423</td>
</tr>
<tr>
<td>- <strong>Non-physician practitioners who are unable to bill E/M services</strong> use G2061-G2063 when the visit pertains to a service that falls within the benefit category of the practitioner:</td>
</tr>
<tr>
<td>- Licensed clinical social worker</td>
</tr>
<tr>
<td>- Clinical psychologist</td>
</tr>
<tr>
<td>- Physical and occupational therapist</td>
</tr>
<tr>
<td>- Speech language pathologist</td>
</tr>
<tr>
<td>- Do not use Modifier 95 since this is not a telehealth code. POS is where the provider was located when conducting the service.</td>
</tr>
<tr>
<td>- Patient initiates service via electronic health record portal, secure email or other digital applications (follow-up by the provider may include telephone).</td>
</tr>
</tbody>
</table>
### Description of Additional Services Permitted by CMS during Public Health Emergency (PHE) (Updated 3-30-20)

#### Telephone E/M Visits (Telemedicine service)

- **Telephone E/M or Assessment or an established patient, parent, or guardian**
  - **Codes for MD, NP, PA:**
    - 99441 5-10 min
    - 99442 11-20 min
    - 99443 21-30 min
  - **Codes for practitioners who cannot bill E/M services**
    - 98966 5-10 min
    - 98967 11-20 min
    - 98968 21-30 min
- **Bundled E/M Services:** 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.

#### Practitioners who may bill these services (Updated 3-3-20)

- Physicians and healthcare practitioners (NP and PA) that can directly bill for E/M services use 99441-99443
- *Non-physician who may not report E/M services use 98966-98968 when the visit pertains to a service that falls within the benefit category of the practitioner:
  - Licensed clinical social worker
  - Clinical psychologist
  - Physical and occupational therapist
  - Speech language pathologist

#### Permitted Technology

- Telephone

#### Other Flexibilities

- **ESRD:** 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.
- **National Coverage or Local Coverage Determinations:** Clinicians will not have to meet requirements for a face-to-face visit for evaluations and assessments.
- **In-person visits for nursing home residents:** CMS is waiving requirements for physicians and non-physician practitioners to perform in-person visits for nursing home residents and allow visits to be conducted as appropriate, via telehealth options.
- **Remote monitoring:** 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)