SPECIAL ISSUE

Editor's Letter

Dear Colleague:

The COVID-19 pandemic is overwhelming health systems around the globe. In the US, CMS and private payers have been rapidly changing payment policies in an attempt to respond to the national crisis. We have accelerated the publication of this issue of Coding and Billing Quarterly to share with you this timely and evolving information, including WHO guidance on ICD-10 coding for COVID-19 related conditions, use of non-face-to-face (NFTF) codes, CMS guidance on the use of telemedicine services and sample scenarios of patient encounters with specific coding recommendations.

Let me share a brief word about what the ATS is doing in response to the pandemic. The ATS has created a COVID-19 webpage with ATS resources and links to other useful clinical and policy resources. Additionally, the ATS has been working with Congress and the highest levels of the Administration to demand an urgent and effective response to the pandemic. Specifically, in March, ATS President James Beck MD, ATSF was on a conference call with President Trump, Vice President Pence, CMS Administrator Seema Verma and other officials demanding that the Administration take immediate action to provide PPE, ventilators and COVID-19 tests to front line clinicians. The ATS has followed this initial interaction with additional correspondence to the Administration and Congress on mounting an effective COVID-19 response. Clearly, there is much more work that needs to be done.

I hope this information is useful. I also want to share my deep appreciation for being part of a profession that is on the front lines of this national and global crisis. Even in the midst of this tragic pandemic, it is inspiring to see the work and dedication of my colleagues. Thank you for being the healers in this time of need. Please be safe and remain healthy through this pandemic!

Sincerely,

Alan L. Plummer, MD

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ATS RESOURCES Coronavirus (COVID-19) Read More

COVID-19 ICD-10-CM Coding Guidelines for 2020

by Alan L. Plummer MD

The Coronavirus (COVID-19) pandemic ravaging the world, including the United States, has resulted in many patient-doctor encounters. It is important to code and bill each visit properly in order to receive the proper reimbursement and is of great importance for appropriate tracking.

In March 2020, the World Health Organization along with the Centers for Disease Control, instituted an emergency use ICD-10-CM code for COVID-19, **U07.1**, 2019 nCoV acute respiratory disease. Codes **U00-U49** are to be used by WHO for the provisional assignment of new diseases of uncertain etiology. **U07.1** should be used instead of **B97.29**, Other coronaviruses as the cause of diseases classified elsewhere, beginning **April 1, 2020**.

The proper CPT code for the patient encounter should always be used, **99201-99205**, **99211-99215**, etc.

For patients presenting with any signs/symptoms (such as cough, fever, etc.) and where a definitive diagnosis has not been established, it is appropriate to assign codes for the presenting symptoms (See **Table**).

The Centers for Disease Control issued official ICD-10-CM Coding Guidelines for COVID-19 on Feb 20, 2020. These Guidelines should be used whenever a patient with suspected or proven COVID-19 has been seen, coded and billed for the encounter. It is recommended that the reason for the encounter (pneumonia, acute bronchitis, ARDS, etc.) be coded first, after which the code for a suspected or proven COVID-19 illness should be used (See **Table**). **U07.1** should be used for a proven case, **Z03.818** for a possible exposure and **Z20.828** for an actual exposure.

For example, code **J12.89**, Other viral pneumonia, for viral pneumonia and **U07.1** should be used for a confirmed case of COVID-19 pneumonia. If the diagnosis has not been confirmed, use **Z03.818** for a possible exposure or **Z20.828** for an actual exposure (See **Table**).

For those patients with acute bronchitis or unspecified bronchitis, code **J20.8**, Acute bronchitis due to other specified organisms, for a proven COVID-19 infection along with **U07.1**. **J40**, Bronchitis, not otherwise specified (NOS), should be used with U07.1 for an established COVID-19 infection. **Z03.818** or **Z20.828** should be used for a possible or an actual exposure (See **Table**). ■

Table: ICD-10-CM Codes

Condition	Code
Possible exposure to coronavirus	**Z03.818**
Actual exposure to coronavirus	**Z20.828**
Proven case of coronavirus	**U07.1**
Pneumonia due to COVID-19	**J12.89**
Adult Respiratory Distress Syndrome (ARDS)	**J80**
Acute Bronchitis	**J20.8**
Bronchitis NOS	**J40**
Acute lower respiratory infection NOS	**J22**
Respiratory infection NOS	**J98.8**
Signs and Symptoms	
Cough	**R05**
Fever, unspecified	**R50.9**
Shortness of breath	**06.02**

References:

CDC: ICD-10-CM Official Coding Guideline-Supplement Coding encounters related to COVID-19 Coronavirus Outbreak. Effective: February 20, 2020.

CDC: New ICD-10-CM code for the 2019 Novel Coronavirus (COVID-19), April 1, 2020. Effective: March 18, 2020

NON-FACE-TO-FACE (NFTF) CODES IN COVID CONTEXT

by Alan L. Plummer, MD/Denise Merlino, CPC, MBA, CNMT

In response to the coronavirus pandemic, CMS has approved 80 codes to be used with telehealth and non-face-to-face encounters (NFTF). NFTF codes can be useful when the physician is asked to address patient problems when the patient is not present. NFTF services include telephone calls, online digital E/M services, inter-professional telephone/internet/ electric health record consultations, digitally stored data services/remote physiologic monitoring, remote reporting of self-measure blood pressure and remote physiologic monitoring treatment management services.

Physicians and other qualified health providers (QHP) may use a **Telephone evaluation** of an established patient, parent or guardian not originating from a related E/M service within the previous seve days. If the telephone evaluation results in an E/M service or procedure within the next 24 hours or on the soonest available appointment, the telephone service codes cannot be used. These codes are for medical discussions, **99441** (5-10 minutes), **99442** (11-20 minutes) and **99443** (21-30 minutes). The place of service (POS) should be what it would have been for a face-to-face service plus a modifier 95 indicating that the service rendered was actually performed via telehealth both for Medicare and for other payers. The payers should be contacted to be certain you have the proper POS to be used. Total non-facility payment for **99441** is $14.44, for **99442** is $28.15 and is $44.14 for **99443**. Because of the current Public Health Emergency (PHE), Medicare and hopefully, most payers, will begin to reimburse for telephone services. During the PHE, qualified non-physician healthcare professionals (eg. physical therapists, occupational therapists, etc.) may use codes **98966**-**98968** for telephone calls, which have the same times and reimbursement as **99441**-**99443** as of April 6, 2020.

Online digital E/M services must be initiated by an established patient electronically via email, a patient portal or other electronic means to the physician or other QHP. These services are reported once for a seven day cumulative service period. These codes are **not** reported if an E/M occurs within 7 days before or after the inquiry from the patient, unless the digital inquiry occurs for a <u>different</u> problem than the problem(s) addressed during the E/M service. Digital services are also not reported for a surgical procedure or in the surgical post op period. More than one QHP can participate during the seven day period and all provider time is accumulated for the total time used in the code. Code **99421** is used for 5-10 minutes, **99422** for 11-20 minute and **99423** for 21 or more minutes. Total non-facility reimbursement for **99421** is $14.52, for **99422** $31.04 and for **99423** $50.16. This encounter and the total time involved should be documented in the medical record.

The Inter-professional Telephone/Internet/Electronic Health Record Consultations Codes are an interesting group as both the referring QHP and the consultant use different codes and are paid separately. The physician or QHP of an established or new patient initiates the consultation. The consultant cannot have the seen the patient within the previous 14 days and, if the consultation results in transfer of care, surgery, hospital, outpatient or other face-to-visit within 14 days or during the next available appointment, these codes are not reported.

The initiating physician or QHP should use code **99452** if the preparation for and the discussion with the consultant is 16-30 minutes. This code should not be used more than once in a 14 day period. If the time exceeds 30 minutes, and the patient is present, the patient's physician or QHP may report the prolonged service codes, **+99354-+99357**. If the patient is not present and the time exceeds 30 minutes, the non-face-to-face prolonged service codes, **99358, +99359**, may be reported.

The consulting physician or QHP has to report back both verbally and by written report to the referring QHP. 50% or greater of the service time reported must be devoted to the medical consultative verbal or

internet discussion and must be documented in the patient's record. Report **99446** for 5-10 minutes of medical consultative discussion and review, **99447** for 11-20 minutes, **99448** for 21-30 minutes, and **99449** for 31 minutes or more. If the consultant desires only to write a report, use **99451** for 5 minutes or more of medical consultative time. The total non-facility reimbursement is $37.53 for **99451** as well as for **99452**, used by the patient's QHP. The total non-facility reimbursement is $18.41, $37.17, $55.58, and $73.98 for codes **99446**-**99449**.

Digitally Stored Data Services/Remote Physiologic Monitoring codes **99453**, **99454** are used to report remote physiological monitoring services (eg. weight, blood pressure, pulse oximetry, respiratory rate) during a 30 day period. The medical device must be defined by the FDA and the service ordered by a physician or QHP. These codes must not be used for monitoring less than 16 days or when these services are included in other codes for the duration of the physiologic monitoring service (eg. continuous glucose monitoring **95250** which requires a minimum of 72 hours of monitoring). Report **99453** for the initial set-up and patient education on the use of the equipment. Report 99454 for 30 days of daily monitoring or programmed alert(s) transmission. Use **99091** to report collection and interpretation of physiologic data (eg. ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient or caregiver or other qualified health care professional (when applicable) requiring a minimum of 30 minutes each 30 days. **99453** and **99454** have no physician work, but pay $18.77 and $62.44 respectively for practice expense. **99091** pays a total non-facility payment of $59.19. Do not report **99453**, **99454** in conjunction with codes for more specific parameter (eg. **93296**, **94670**). Do not report **99091** in conjunction with **99457**.

Two new codes, **99473**, **99474,** have been approved for self-measured blood pressure monitoring. The device must be validated for clinical accuracy. Report **99473** for patient education/training and device calibration.

Report **99474** for separate self-measurements of two readings, one minute apart, twice daily over a 30 day period (minimum of 12 readings). The collection of data is reported by the patient or caregiver to a QHP with a report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient. **99473** and **99474** have no physician work, but pay $11.19 and $15.16 for practice expense. **99474** must not be reported more than once per calendar month and can't be reported in the same month as **99453**, **99454**, **99457**, **+99458** or **99091**.

Remote Physiologic Monitoring Treatment Management Services are provided when clinical staff/physician/other QHP use the results of physiological monitoring to manage a patient under a specific treatment plan. The device used must be a medical device as defined by the FDA and the service must be ordered by a physician or a QHP. Codes **99457**, **+99458** require a live, interactive communication with the patient/caregiver. For the first 20 minutes of clinical staff/physician/QHP time in a calendar month use **99457** and report **+99458** for each additional 20 minutes. The total non-facility payment for **99457** is $51.61 and for **+99458** is $42.22. Do not report services of less than 20 minutes. Report **99457** one time regardless of the number of physiologic monitoring modalities performed in a calendar month. Do not report **+99458** for services of less than 20 minutes. Do not report **99457** in conjunction with **99091** or in the same month as **99473**, **99474**.

Use of NFTF codes can enhance practice income when used judiciously and recoup payments for time not previously requested! ◼

References:

CPT 2020: pp 32,33,39-43.
https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-06990.pdf?utm_campaign=pi+subscription+mailing+list&utm_source=federalregister.gov&utm_medium=email

Billing Scenarios Under COVID Rules

by Omar Hussain, DO

As our Pulmonary, Critical Care, and Sleep Medicine community searches for the best pathways to deliver care for our patients with COVID-19, we will also find creative solutions for evaluating and managing all of our patients' problems during this time of social distancing. It may feel wrong to worry about coding, billing, and payment during this crisis. But part of what we need to do is measure our effort in unconventional settings. Over the past few weeks, CMS has relaxed regulations and facilitated keeping providers and patients safe. Here are suggestions on how to document and code for these episodes of care.

Office Setting

Certifying/Recertifying oxygen and positive airway pressure

Scenario: A Medicare patient needs home oxygen (NCD 240.2), CPAP for OSA (NCD 240.4) respiratory assist device/ventilator for home use (LCD L33800), or oxygen and oxygen equipment (LCD L33797).

Rule during public health emergency (PHE): It is acceptable to order without a face-to-face visit to certify/recertify these durable medical equipment items. During this public health emergency, CMS will not enforce the clinical indications for coverage. CMS has allowed licensed practitioners practicing within their scope of practice, such as nurse practitioners and physician assistants, to order Medicare/Medicaid home health services[i]. This authority includes orders for durable medical equipment and supplies for home use.

"Virtual" outpatient visits

Scenario: Using an acceptable, **interactive real-time audio and video telecommunication (RAVT)** system to perform an evaluation and management visit for a new or established outpatient. Examples of a RAVT include Apple Face Time, Google hangouts, Skype, and doxy.me (not all-inclusive). Provider should not use Facebook Live, TikTok, or other public facing communication services. Provider documents it was a real time audio and video telecommunication visit.

Rules during PHE: Consent for this type of visit should be obtained annually. It is acceptable to obtain consent verbally at the time of service, and it is acceptable for auxiliary staff to document consent. Use the codes normally used for outpatient E/M: **99201-99215** (office or other outpatient visits). When submitting the bill to Medicare, Place of Service (POS) designation is equal to what it would have been had the service been furnished in-person[ii]. Therefore, for outpatient visit use POS 11 (office), also include "Modifier 95", indicating that the service rendered was actually performed via telehealth. CMS is not requiring the CR (catastrophe/disaster related) modifier on telehealth services. Select the E/M based on medical decision making or the total time spent caring for the patient on that day. CMS plans to reimburse at the same level as a face-to-face visit. Modifiers and POS designation may be different for state health insurance plans and likely different for private payors.

Brief assessment of an outpatient's question

Scenario: A brief (5-10 minute) check in between Physician/Advanced Practice Provider and a new or established outpatient via telephone or other telecommunications device (audio/video, secure text message, patient portal) to decide whether an office visit or other service is needed. This check in does not originate from a related E/M service provided within the previous 7 days nor does it lead to an E/M service or procedure within the next 24 hours. No frequency limitations.

Rule during PHE: During PHE, this rule covers new and established patient. Use HCPCS code **G2012**. It has 0.25 wRVU's/$14.80 for a non-facility payment.

Telephone calls

Scenario: A **telephone** call is initiated by either a **new or established patient** and the patient speaks with a **physician**. This telephone call does not originate from a related E/M service provided within the previous 7 days nor does it lead to an E/M service or procedure within the next 24 hours.

Rule during PHE: For the duration of the PHE, **99441-99443** can be used for both new and established patients. **99441** (5-10 minutes) has 0.25 wRVU/$14.44. **99442** (11-

20 minutes) has 0.50 wRVU's/$28.15, and **99443** (21-30 minutes) has 0.75 wRVU's/$41.14.

Scenario: Same as above, but performed by a qualified non-physician healthcare professional.

Rule during PHE: For the duration of the PHE, **98966-98968** can be used for both new and established patients. **98966** (5-10 minutes) has 0.25 wRVU/$14.44. **98967** (11-20 minutes) has 0.50 wRVU's/$28.15 and **98968** (21-30 minutes) has 0.75 wRVU's/$41.14. The reimbursement is the same as for physicians.

Patient sends the office a video or image to review

Scenario: A remote evaluation of a recorded video and/or images submitted by an **established** outpatient. This includes interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours, or soonest available appointment.

Rule: Use HCPCS code **G2010**. It has 0.18 wRVU's/$12.27 non-facility payment.

Patient and provider exchange messages

Scenario: An **established** outpatient initiates communication with a **physician** through electronic medical record inbox. The **physician** reviews the initial patient inquiry, medical history, documents sent by the patient and/or obtained by clinical staff. He/she formulates and sends a response (eg, a diagnosis and treatment plan, and/or request for additional information). The physician reviews the test results and other reports. Emails prescriptions are sent. The physician conducts follow-up communication with the patient and interacts with the clinical staff to order diagnostic tests, coordinate care, and implement the care plan. The physician documents the cumulative time during a seven-day period.

Rule: Use **99421** for **5-10 minutes**, 0.25 wRVU's, $15.52 non-facility payment. Use **99422** for **11-20 minutes**, 0.50 wRVU's, $31.04 and use **99423** for **21+ minutes**, 0.80 wRVU's, $50.16.

Scenario: Same as above. But performed by a qualified non-physician healthcare professional.

Rule: Use **G2061-G2063**. wRVU's are 0.25/$12.27, 0.44/$21.65, and 0.69/$33.92

Patient with complex medical history transfers care and has a binder of papers

Scenario: For a **non face-to-face** service between 30-74 minutes (first hour) which occurs before and/or after a face-to-face visit with an established patient. Service includes reviewing records and communications (telephone, patient portal) that are documented and performed by physicians or advanced practice provider. This service can be the same or different single date as the face-to-face visit. The time does not need to be continuous.

Rule: For the first hour, use **99358**, 2.10 wRVU's, $114. For **each additional 30 minutes**, use **+99359**, 1.00 wRVU's/$55.

Office staff reviews a month of patient home pulse oximetry

Scenario: During a calendar month, the office staff and physician combine for 20 minutes of time remotely reviewing a patient's oxygen saturation levels using pulse oximetry. Either office staff or physician interactively communicates with the patient.

Rule: **99457** has a wRVU 0.61 and the Medicare non facility payment is $51.61. For each additional 20 minutes, use **+99458**. The wRVU and payment are the same as for **99457**.

"Goals of care" discussion done via Skype

Scenario: Using an interactive real-time audio and video telecommunication (RAVT) system to perform an advance care planning visit. This visit includes explanation and discussion of advance directives by a physician or other qualified health care professional with the patient, family members(s), and/or surrogate. Provider documents it was a real time audio and video telecommunication visit.

Rule during PHE: Use the codes that are normally used for Advanced Care Planning, E/M: **99497** for the first

30 minutes and +**99498** each additional 30 minutes. When submitting the bill to Medicare, Place of Service (POS) designation is equal to what it would have been had the service been furnished in-person[iii]. Also include "Modifier 95", indicating that the service rendered was actually performed via telehealth. CMS is not requiring the CR modifier on telehealth services. **99497** (first 30 minutes) has a wRVU 1.50 and the Medicare non facility payment is $86.98. For each additional 30 minutes, use +**99498**, 1.40 wRVU's/$76.15.

Hospital wards

"Virtual visit" for Pulmonary inpatient consult service

Scenario: Using an interactive real-time audio and video telecommunication (RAVT) system to perform an **initial** E/M visit for an **inpatient**. Examples of a RAVT include Apple Face Time, Google hangouts, Skype, and doxy.me (not all-inclusive). Provider documents it was a real time audio and video telecommunication visit.

Rule during PHE: Use the codes that are normally used for "Initial hospital care", E/M: **99221-99223**[iv]. When submitting the bill to Medicare, Place of Service (POS) designation is equal to what it would have been had the service been furnished in-person[v]. Also include "Modifier 95", indicating that the service rendered was actually performed via telehealth. CMS is not requiring the CR modifier on telehealth services. Select the E/M based on medical decision making or total time spent on the care for the patient that day. CMS plans to reimburse at the same level as a face-to-face visit[iv]. Modifiers and POS designation may be different for state health insurance plans and likely different for private payors.

Scenario: Using interactive a real-time audio and video telecommunication (RAVT) system to perform a **subsequent** E/M visit for an **inpatient**. Provider documents it was a real time audio and video telecommunication visit.

Rule during PHE: Use the codes that are normally used for subsequent hospital care service, E/M: **99231-**

99233[viii]. During the PHE, a subsequent inpatient visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every three days.

The curbside consult code

Scenario: The primary care provider calls you for advice regarding an inpatient with intermittent, chronic cough. The patient is about to go home and does not plan to be seen by Pulmonary in the office. The pulmonologist reviews prior pulmonary function tests, chest imaging, the medication list and provides a verbal and written report to the primary care provider. The pulmonologist documents the time, gives a verbal report as well as a written report to the patient's primary care provider. The primary care provider may code **99452 for 16-30 minutes of time (wRVU 0.70/$37.53) and can use prolonged service codes (+99354-+99357) for time greater than 30 minutes**

Rule: Use the interprofessional telephone/Internet/electronic health record consultation **99446-99449**. Use **99446** for 5-10 minutes, 0.35 wRVU's/$18.41. Use **99447** for 11-20 minutes, 0.70 wRVU's/$37.17. Use **99448** for 21-30 minutes, 1.05 wRVU's/$55.58 and use **99449** for >31 minutes, 1.40 wRVU's/$73.98. If the consultant desires only to provide a written report, use **99451** for greater than 5 minutes (wRVU 0.70/$37.53)

Intensive Care Unit

Critical Care without being in the patient's room

Scenario: A patient with COVID-19 is intubated and sedated for acute hypoxic respiratory failure. The patient is seen through the glass door. Thirty-five minutes is spent in the care of the patient that day and the physician was in the ICU during that time. No procedures are performed.

Rule: Use critical care services code **99291**. A physical exam is not required for either **99291** or **99292**. Use **99292** for each 30 minutes beyond the initial 74 minutes.

99291 and **99292** are time-based codes, so be sure to document the time spent on the patient.

Scenario: A patient with COVID-19 is intubated and sedated for acute hypoxic respiratory failure. Using an interactive real-time audio and video telecommunication (RAVT) system, the physician performs 35 minutes of critical care management that day from a remote location. Examples of a RAVT include Apple Face Time, Google hangouts, Skype, and doxy.me (not all-inclusive). The provider documents it was a real time audio and video telecommunication visit.

Rule during PHE: Use **99291**[viii] (wRVU 4.50, $284.75). When submitting the bill to Medicare, the Place of Service (POS) designation is equal to what it would have been had the service been furnished in-person[ix]. Also include "Modifier 95", indicating that the service rendered was actually performed via telehealth. CMS is not requiring the CR modifier on telehealth services. CMS plans to reimburse at the same level as a face-to-face visit[x]. Modifiers and place of service designation will likely be different for state health insurance plans and for private payors. Use **99292** for each 30 minutes beyond the initial 74 minutes that day. The wRVU for **99292** is 2.25, $125.95.

Prior to this public health emergency, HCPCS code **G0508** was created as a telehealth consultation, critical care, initial code. To use G0508, physicians typically spend 60 minutes communicating with the patient and providers via telehealth and the wRVU is 4.00, $214.37. **G0509** is the subsequent day code and physicians typically spend 50 minutes communicating with the patient and providers via telehealth. The wRVU for **G0509** is 3.86, $197.77.

Scenario: The resident is inserting a central line

Rule during PHE: The teaching physician must provide supervision either with physical presence or be present through interactive telecommunications technology during the key portion of the service. CMS believes that use of RAVT technology allows for the teaching physician to furnish assistance and direction without requiring the teaching physician's physical presence for the key portion of the service[xi]. Use **36556** (wRVU 1.75/$88.78) for the central line placement and, if interactive telehealth technology was used, submit

the usual location for the POS and add modifier 95 to indicate the service was provided by telehealth

Tiered ICU staffing model during a pandemic

Scenario: The intensivist is in the ICU and is supervising a team of anesthesiologists and hospitalists who are caring for over 40 patients with COVID-19 and acute respiratory failure. While the intensivist is assisting in decision making ranging from ventilator settings to strategies for vasopressors and sedation, the intensivist does not spend 30 minutes caring for any single patient. The intensivist documents his role in succinct notes. The hospitalists and anesthesiologists are appropriately documenting either an E/M note or a critical care note.

Rule: Describe the ventilator management and use **94002** (wRVU 1.99, $94.92) for the first day. For subsequent days, use **94003** (wRVU 1.37, $68.57). Ventilator management codes cannot be done remotely.

Many medical societies have provided valuable coding advice during the COVID-19 public health emergency. A useful guide is produced by the American Medical Association at https://www.ama-assn.org/system/files/2020-04/covid-19-coding-advice.pdf ∎

References:

[i] https://www.federalregister.gov/documents/2020/04/06/2020-06990/medicare-and-medicaid-programs-policy-and-regulatory-revisions-in-response-to-the-covid-19-public#h-93 (section II, paragraph Z)

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

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

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

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

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

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

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

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

[x] https://www.federalregister.gov/documents/2020/04/06/2020-06990/medicare-and-medicaid-programs-policy-and-regulatory-revisions-in-response-to-the-covid-19-public#h-58 (Section II, paragraph O)

Question & Answer:
COVID-19 Billing Questions

Remote Vent Management

Question: As the volume of ventilator dependent patients outside the critical care units rises we have been asked to follow them remotely and besides direct communication with the primary teams, to document our recommendations in the chart. Should we document these as inpatient e-consults? I understand that you can only bill for 1 e-consult during a patient's hospitalization but these patients may require daily follow up.

Answer: Our recommendation would be to document your remote inpatient services provided and document the intervals of times throughout the day or days requested. CMS has relaxed and added the inpatient initial, subsequent in-patient observation and emergency care CPT codes as well as yes even the critical care codes. Additionally, use of time is another method for code selection. All of these are temporary, and CMS is allowing all via Telehealth, this means you need a video and telephone combination for a Medicare patient. We are told by CMS most recently that POS would be the site you would normally report and add the modifier 95 to identify that is was conducted remotely.

Further, assuming audio and video are available as you implied in your email, use an inpatient codes **99221-99223** for the first day and **99231-99233** for subsequent days with the inpatient POS and 95 modifier.

However, if audio **and** video are NOT available and a provider is simply talking with another physician/QHP over the phone about these patients, then could use the interprofessional assessment and management codes, **99446-99449**. Time based and ranging from 5 min to >31 min. Then provide a verbal and written report. The provider can't have had a face to face contact the prior 14 days and the next 14 days. The wRVU's range from 0.35 (5-10 min) to 1.40 (>31min).

We do understand that you are likely performing ventilator management services, however as of today those CPT codes are not part of the allowed emergency telehealth at this time.

Oxygen Certification/Recertification

Question: Do patients need to come into the office for an E/M to renew their oxygen prescription?

Answer: No, CMS has issued a temporary waiver for in-person visit to certify or recertify several respiratory related services including supplemental oxygen, CPAP and respiratory assist devices.

Alpha-1 & Home Infusion

Question: Do alpha-1 patients need to attend institution based facilities to receive augmentation infusion therapy?

Answer: No, CMS issued a broad policy waiver that allows Medicare patients who receive infusion therapy to transition to home-based infusion services during the covid crisis. While the policy does not specifically list apha-1 in the waiver policy, the ATS believe the broad waiver issued by CMS covers alpha-1 patients. The ATS has contacted CMS to encourage explicit clarification the alpha-1 is covered in the waiver policy.

Site of Service Modifiers

Question: I am unclear how to report services that are now expanded and telehealth is allowed, do I need a modifier, what are the rules?

Answer: Building on prior action to expand reimbursement for telehealth services to Medicare beneficiaries, CMS will now allow for more than 80 additional services to be furnished via telehealth. When billing professional claims for all telehealth services with dates of services on or after March 1, 2020, and for the duration of the Public Health Emergency (PHE), bill with:

- Place of Service (POS) equal to what it would have been had the service been furnished in-person

- Modifier 95, indicating that the service rendered was actually performed via telehealth

As a reminder, CMS is not requiring the CR modifier on telehealth services. However, consistent with current rules for telehealth services, there are two scenarios where modifiers are required on Medicare telehealth professional claims:

- Furnished as part of a federal telemedicine demonstration project in Alaska and Hawaii using asynchronous (store and forward) technology, use GQ modifier

- Furnished for diagnosis and treatment of an acute stroke, use G0 modifier

There are no billing changes for institutional claims; critical access hospital method II claims should continue to bill with modifier GT.

Telemedicine and Interrupted Video Service

Question: What do I do if the video portion of my video visit fails in the middle of the visit? Do I still bill the E/M code or do I drop to a telephone call?

Answer: As with any CPT code, we expect that the majority of the service is performed before you would bill that CPT code. Therefore the answer depends, if you were able to obtain the pertinent information via video to meet the elements of the code, then bill the E/M code under telemedicine. However, if you did not really meet the elements, and there is another CPT code that better represents that service then you are obligated to drop to that lower code. This is not a change in CMS policy and just makes sense. ◼