Coronavirus (COVID-19) & Telehealth Billing and Coding Updates

April 6, 2020

The guidance and information provided in this webinar was current at the time of presentation and recording. For up-to-date information after **April 6th at 10 am CST**, please visit https://www.revelemd.com/blog/billing-and-coding-for-coronavirus

REVELE

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Agenda

- **Coronavirus**
  - Testing
  - Confirmed Cases
  - Reimbursement
- **Telehealth, e-Visits and Virtual Check-Ins**
  - Emergency Declaration
  - Codes
  - Eligible Providers
  - Claim Requirements
- **eClinicalWorks TeleVisits**

Coronavirus Testing

Laboratory CPT/HCPCS Codes:

- **U0001:** 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Panel: To be used when the specimen is sent to the CDC or a CDC approved local/state health department laboratory (not effective until April 1st)
- **U0002:** 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non CDC: To be used when specimens are sent to commercial laboratories e.g. Quest or LabCorp, and not to the CDC or CDC-approved local/state health department laboratories (not effective until April 1st)
- **87635:** SARS-COV-2 COVID-19 AMP/PRB (effective date of service and billing date 3/13/20)
- **G2023** Independent labs report this code when a trained laboratory technician collects a nasopharyngeal, oropharyngeal, sputum, or another type of specimen for the purpose of performing a laboratory test for the SARS–CoV–2 virus. (effective date of service and billing date 3/1/20)
- **G2024** Specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) from an individual in a SNF or by a laboratory on behalf of a Home Health Agency, any specimen source (effective date of service and billing date 3/1/20)

Specimen Transfer

- **99000** Handling and/or conveyance of specimen for transfer from the office to a laboratory
- **99001** Handling and/or conveyance of specimen for transfer from the patient in other than an office to a laboratory
- **99211** for swabs collected at office or group practice testing site. Append modifier 25 if same day as assessment.

Coronavirus Testing

Diagnosis Codes

Exposure:

- **Z03.818:** Encounter for observation for suspected exposure to other biological agents ruled out. To be used where there's a concern about a possible exposure to COVID-19 but this is ruled out after evaluation
- **Z20.828:** Contact with and suspected exposure to other viral communicable diseases. To be used when there is an actual exposure to someone who is confirmed to have COVID-19

Signs and Symptoms

For patients presenting with any signs/symptoms and a definitive diagnosis hasn't been established, assign the appropriate code(s) for each of the presenting signs and symptoms:

- Cough: **R05**
- Fatigue: **R53.83**
- Fever: **R50.9**
- Sore throat: **J02.9**

Confirmed Coronavirus Cases

Concern Cases

- **Z71.84** Encounter for health counseling related to travel
  Encounter for health risk and safety counseling for (international) travel
- **Z71.1** Person with feared health complaint in whom no diagnosis is made
  Person encountering health services with feared condition which was not demonstrated
  Person encountering health services in which problem was normal state 'Worried well'
  Excludes1: medical observation for suspected diseases and conditions proven not to exist (Z03.-)

Confirmed cases

- Report the code for the patient's condition that is related to the COVID-19 **(example J12.890-other viral pneumonia**) and **B97.29**-Other coronavirus as the cause of diseases classified elsewhere
- **U07.1:** 2019-nCoV acute respiratory disease (effective 4/1/2020)
- **U07.2:** COVID-19, virus not identified is assigned to a clinical or epidemiological diagnosis of COVID-19 where laboratory confirmation is inconclusive or not available

Are these codes in my eClinicalWorks system?

The diagnosis codes should be present in your system. If you are a Revele client and are unable to find them, please contact your Client Success Team for assistance.

IMO Update

<u>On January 30, IMO released 15 new descriptors</u> to help clinicians more accurately record diagnoses related to COVID-19.

On **March 26**, as part of our March problem terminology release, that number will increase to 136 terms.

In addition, IMO has created **IMO Precision COVID-19 Sets**, which includes two new value sets aimed at helping providers with workflow and cohort management connected to the coronavirus. IMO Precision COVID-19 Sets will be made available to all customers, **completely free of charge**, helping them to:

- Leverage health information systems to **identify and monitor patients who have documented COVID-19 problems and diagnoses**
- **Analyze the effectiveness** of an institution's COVID-19 management protocol

IMO Update

- Infection due to 2019 novel coronavirus
- Infection due to 2019-nCov
- Infection due to Wuhan coronavirus
- Pneumonia due to 2019 novel coronavirus
- Pneumonia due to 2019-nCov
- Pneumonia due to Wuhan coronavirus
- Exposure to 2019 novel coronavirus
- Exposure to 2019-nCov
- Exposure to Wuhan coronavirus
- Real time reverse transcriptase PCR positive for 2019 novel coronavirus
- Real time reverse transcriptase PCR positive for 2019-nCov
- Real time reverse transcriptase PCR positive for Wuhan coronavirus RNA
- Suspected 2019 novel coronavirus infection
- Suspected 2019-nCov infection
- Suspected Wuhan coronavirus infection

Coronavirus Claims and Reimbursement

Can claims be submitted now for coronavirus testing or do they need to be held?

CMS became ready to accept claims as of **4/1/2020** for dates of service effective 2/4/20 and forward (until further notice).

Will patients be paying out of pocket for coronavirus testing?
This is to be determined.

What are the average reimbursement rates for coronavirus testing from major carriers such as BCBS, UHC, Cigna, Aetna, etc.?

These rates are to be determined from commercial payers.

Reimbursement

Reimbursement rates are to be determined from payers.

Medicare:

- Medicare covers the lab tests for COVID-19. The patient pays no out-of-pocket costs. As of 3/19/20, the CDC test will be reimbursed at $36 and testing through other entities will be at $51.
- If you have a Medicare Advantage Plan, you have access to these same benefits. Medicare allows these plans to waive cost-sharing for COVID-19 lab tests.

Blue Cross Blue Shield:

- Waive prior authorizations for diagnostic tests and covered services; applies to all business lines

United Healthcare:

- UnitedHealthcare will cover testing for Coronavirus (COVID-19) at approved locations for insured, Medicaid and Medicare members.

Reimbursement *(cont.)*

Reimbursement rates are to be determined from payers.

Cigna:

- Will allow co-pays or cost-shares to be waived
- Click here to learn more about Cigna's response to COVID-19

Aetna:

- Will waive member costs associated with diagnostic testing at any authorized location for all commercial, Medicare, and Medicaid lines of business

Catastrophic Plans:

- How are these designed?
- Do these plans cover the diagnosis and treatment of COVID-19?
- Will the HHS allow issuers of these plans to provide coverage even if the enrollee's deductible hasn't been met?

Uninsured Patients

- Will funding be available to diagnose or treat uninsured patients?
- How will claims be submitted?

Emergency Declaration

On **March 17, 2020**, the Trump Administration announced that Medicare would expand telehealth/virtual visit coverage that allows beneficiaries to receive a wider range of healthcare services from their providers without having to travel to a healthcare facility.

Beginning on **March 6, 2020,** Medicare (administered by CMS) will temporarily pay approved providers to service beneficiaries residing across the entire country through telehealth.

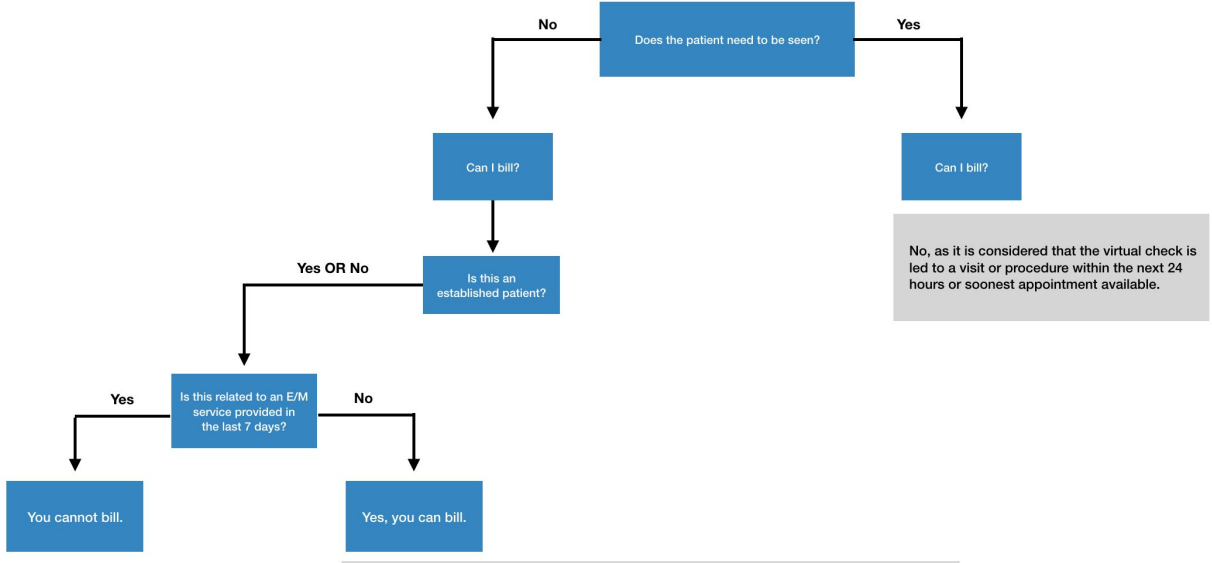
Highlights:

- Telehealth Waiver
- Provider and patient at separate locations
- Telehealth not limited to COVID-19
- Telehealth Medicare reimbursement

Telehealth, Virtual Check-Ins, E-visits

Type of Service	What is the service?	HCPC/CPT Code	Patient Relationship with Provider
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient.	Common telehealth services include: • 99201-99215 (Office or other outpatient visits) • G0425-G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406-G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs). For a complete list: https://www.cms.gov//Medicare/Medicare-generalinformationtelehealth/telehealth-codes	For new* or established patients. *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.
VIRTUAL CHECK-IN	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by a new or established patient.	• HCPCS code G2012 • HCPCS code G2010 • HCPCS code G0071 • CPT code 99441-99443 (as of 3/30/30) for physicians, NP's, PA's (not POS 02) • CPT code 98966-98968 (as of 3/30/20) for other qualified HCP's (not POS 02)	For new and established patients
E-VISITS	A communication between a patient and their provider through an online patient portal	• 99421 • 99422 • 99423 • G2061/98970 • G2062/98971 • G2063/98972	For established patients

Virtual Check-In



G2012: Brief discussion (5-10 minutes) with the patient as a communication technology-based service

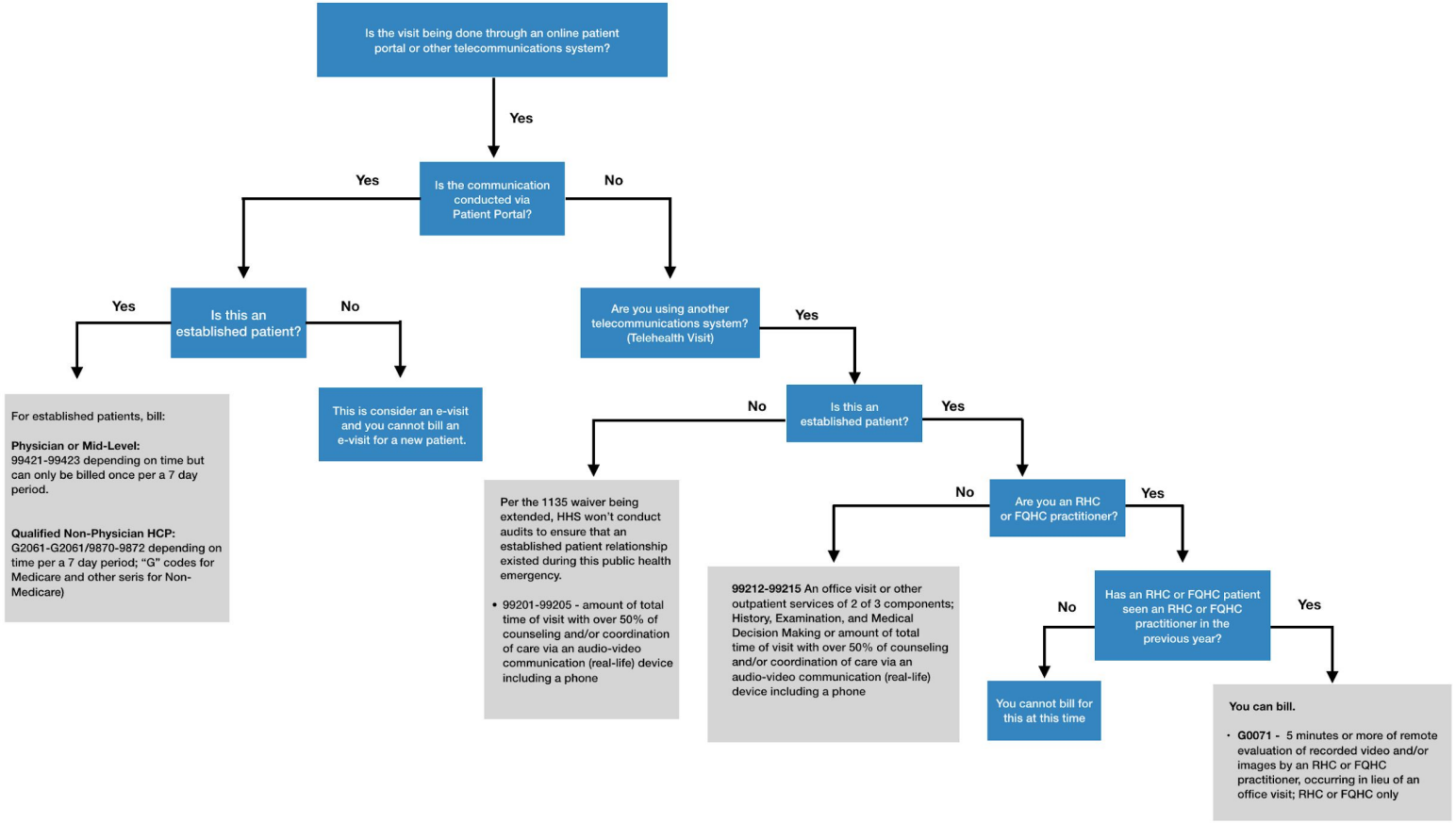
G2010: Evaluation of a recorded video or images submitted by the patient which includes interpretation and follow up with that patient within 24 business hour

G0071: Virtual check-in for an FQHC/RHC; but similar to G2012

CPT code 99441-99443 (as of 3/30/30) for physicians, NP's, PA's (not POS 02)
99441: A telephone evaluation and management service provided by a physician to an established patient not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

CPT code 98966-98968 (as of 3/30/20) for other qualified HCP's (not POS 02)
98966: Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

E-Visits and Telehealth



Telehealth & Virtual Visits

Telehealth Codes

The codes that will be billed for what Medicare actually defines as Medicare “telehealth services” will typically be standard E&M office visit codes (such as 99213, 99214) along with a telehealth place of service, and potentially a modifier (if required by commercial payers).

Virtual Based Visits

The Medicare “communications based technology” codes are split into two different service types known as Virtual Check In or E-Visits. Neither of these visits are deemed by CMS to be Medicare “telehealth services” which means they are not subject to the typical statutory restrictions regarding originating site or rural geography.

A virtual check-in is a brief (5-10 minutes) communication initiated by the patient with a practitioner via telephone or other telecommunications device to determine if an office visit is needed. Virtual check-in’s do require an established patient relationship (seen by the provider within the last three years) which hasn’t been waived by CMS due to this public health emergency. A virtual check-in cannot be related to a medical visit within the previous seven days and does not lead to a medical visit within the next 24 hours (or soonest appointment available).

Virtual Check-Ins

Virtual Check-Ins

- **G2012**: Brief communication technology-based service by a physician or other qualified health professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest appointment available; 5-10 minutes or medical discussion
- **G0071**: Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an rural health clinic (rhc) or federally qualified health center (fqhc) practitioner and rhc or fqhc patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an rhc or fqhc practitioner, occurring in lieu of an office visit; rhc or fqhc only
- **99441:** Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
- **98966**: Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
- **G2010**: Remote evaluation of a recorded video and/or images submitted by an established patient, including interpretation and follow-up with the patient within 24 business hours, not originating from a relation E/M service provided within the previous seven days nor leading to an E/M service within the next 24 hours or soonest available appointment.

E-Visits

E-visits are different from telehealth visits because they must occur through an online patient portal. This service is non-face to face; both MD's and mid-levels are eligible to bill for this service. This code series is also time-based and specific documentation requirements must be met.

99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

99421, 99422, and 99243 can only be billed once per 7 days. You will see in the code description that states the time is cumulative - your provider can sum up the time spent with the patient and bill accordingly. Note, the provider can not include time spent with other services with these codes. Services can not be billed on the same day as an office visit or consult. This service is not billable if the patient was treated within 7 days of the E/M for the **same symptom**.

E-Visits

E-Visits by a Qualified Non Physician Health Care Professional

Medicare	Non-Medicare	Description
G2061	98970	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
G2062	98971	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
G2063	98972	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

Federally Qualified Health Center (FQHC) & Rural Health Clinics (RHC)

Specific to Virtual Check-Ins:

Effective January 1, 2019, FQHCs & RHCs can receive payment for virtual check-in services when:

- At least 5 minutes of communication technology-based or remote evaluation services are furnished
- An FQHC/RHC practitioner provides virtual communication service to a patient who has had an FQHC/RHC billable visit within the previous year
- The medical discussion or remote evaluation is for a condition not related to an FQHC/RHC service provided within the previous 7 days, and does not lead to an FQHC/RHC visit within the next 24 hours or at the soonest available appointment.
- Use HCPCS code G0071 (Virtual Communication Services) either alone or with other payable services.

See **Virtual Communication Services Frequently Asked Questions (PDF)**

Televisits Documentation Requirements

Documentation Requirements: The Televisits (Telehealth, Virtual Check-ins, and e-Visits) should be documented in the medical record.

Minimum required documentation elements include:

1. Notation of the patient's initiation and verbal or written consent to the televisit
    - Providers may contact patients to inform of the new televisits' rules, upon the patient's consent, the provider can provide health care during the same call.
2. Names of all people present during a televisit and their role
3. Chief complaint or reason for the televisit
4. Relevant history, background, and/or results
5. Assessment
6. Plan of care or next steps
7. Total time spent of the televisit service

Telehealth

Eligible Telehealth Providers

- Physicians,
- Nurse Practitioners (NPs)
- Physician Assistants (PAs)
- Certified Nurse-Midwives (CNMs)
- Clinical Nurse Specialists (CNSs)
- Certified Registered Nurse Anesthetists (CRNAs)
- Clinical Psychologists (CPs)
- Clinical Social Worker (CSWs)
- Registered Dietitians (RDs) or Nutritional Professionals

It's standard for telehealth that providers must be licensed in the state in which he/she is rendering services. But on 3/18/20, Vice President Mike Pence announced that the Department of Health and Human Services will issue a regulation that allows medical professionals to practice in states where they are not licensed.

Telehealth

Originating Site

An originating site authorized by law includes:

- Office of physician or practitioner
- Hospital Critical Access Hospital (CAH)
- Rural Health Clinic (RHC)
- Federally Qualified Health Center (FQHC)
- Hospital-based or CAH-based Renal Dialysis Center
- Skilled Nursing Facility (SNF)
- Community Mental Health Center (CMHC)

Though Telehealth visits typically include an originating site, CMS is waiving the requirement therefore patients can receive telehealth services in their home. In addition, Telehealth visits are usually limited to patients in rural areas but CMS has waived this requirement.

Telehealth

Distant Site Practitioners

Though subject to state law, includes:

- Physician Nurse practitioner (NP)
- Physician Assistant (PA)
- Certified Nurse-midwife (CNM)
- Clinical Nurse Specialist (CNS)
- Certified Registered Nurse Anesthetist (CRNA)
- Clinical Psychologist (CP)
- Clinical Social Worker (CSW)
- Registered Dietitian or Nutrition Professional (MNT)

A medical professional is not required to present the beneficiary to the physician or practitioner unless it is medically necessary. The decision of medical necessity is made by the physician or practitioner at the distant site.

Telehealth FAQs

Will patients owe a copay?
Many plans are saying they are waiving copays until further notice.

- **Medicare:** Per CMS, the anti-kickback rule for any services paid by Medicare, Medicaid, or CHIP will not be enforced in regards to telehealth visits. This means that providers can reduce or waive cost-sharing for telehealth visits without penalty but they aren't required to waive the fees.
- **Aetna:** For the next 90 days, Aetna will offer zero co-pay telemedicine visits – for any reason
- **Humana**: Currently waiving member cost share for urgent telehealth visits over the next 90 days. Because of this you shouldn't collect payment from Humana Medicare Advantage, Medicaid, and Commercial HSA patients for these services.
- **Magellan Behavioral Health:**
  - During the crisis, normal protocols are being waived to allow for telecommunications based visits
  - Prior authorization process still active
- **Medicaid (by state):**
  - https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/federal-disaster-resources/index.html

Telehealth FAQs

Can I provide telehealth/virtual based services to all patients and be reimbursed or do they have to be experiencing symptoms of the coronavirus/high risk patients?

Per CMS, during this Public Health Emergency they will not enforce the prior-relationship requirement for telehealth/virtual based visits.

Are telehealth documentation requirements the same as a face to face encounter?
The use of a telecommunications system may substitute for an in-person encounter.

All that is seen, communicated, discussed and treated should reflect in the medical record documentation.

Are you an FQHC or RHC?

- Televisits/e-Visits
- Virtual Check-Ins
- https://www.cchpca.org/sites/default/files/2020-03/CORONAVIRUS%20TELEHEALTH%20POLICY%20FACT%20SHEET%20MAR%2016%202020%203%20PM%20FINAL.pdf

Are wellness visits eligible to be done and reimbursed through telehealth/virtual based services?

TBD as payer specific

- CareFirst BCBS
    - https://individual.carefirst.com/carefirst-resources/pdf/carefirst-telemedicine-code-modifier.pdf

Telehealth Claim Requirements

What place of service do I bill for telehealth?

The correct place of service for telehealth is 02 for visits considered telehealth, otherwise use POS 11 if conducted in an office setting (or other POS based on setting).

Essentially, if the services would have been provided in person had this emergency not been going on, you will bill the place of service based on where it would have occurred, example: POS 11. But if it's a true telehealth service, bill POS 02.

What modifiers do I need?

- **Modifier 95** - Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System. Append modifier 95 with E/M codes 99201-99215.
- **Modifier GQ -** Services provided via asynchronous telecommunications system
- **Modifier GT -** Services provided via interactive audio and video telecommunications systems
- **Modifier G0** (G–zero) denotes that a provider diagnosed, evaluated, or treated a patient for an acute stroke remotely using an audio and/or video telecommunication system.

TeleVisits

eClinicalWorks Requirements

Activate Televisits in eClinicalWorks

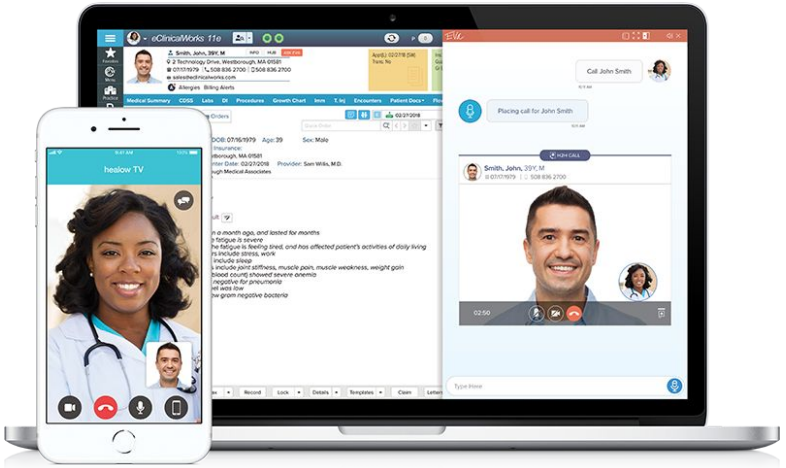
- Cost: $50 per 250 minutes per month or $2 per call
- Setup required

Providers choose whether to use E or EXE version

- The E version (browser) is easier to navigate and use.
- The EXE will require additional setup.

Patient use

- The patient is required to access TeleVisit appointment through Patient Portal or the Healow application. Patients must therefore be web enabled through an email address.



eClinicalWorks Webinars

TeleVisit Webinars

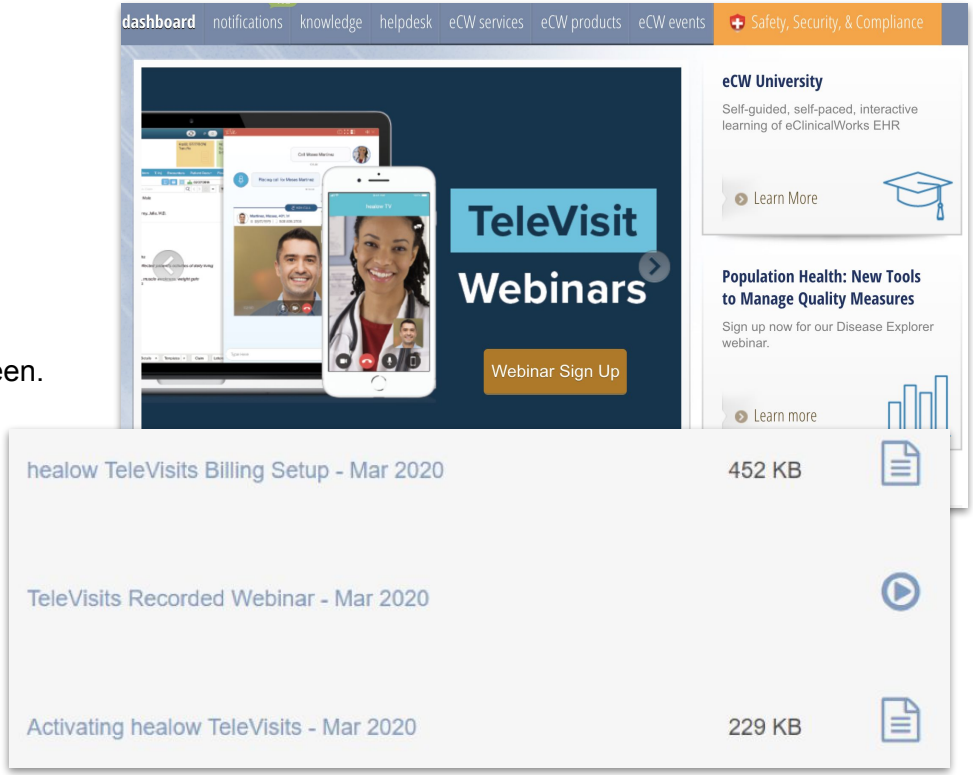
Login to my.eclinicalworks.com
Knowledge > Live Webinars > TeleVisits

You can also find access to the TeleVisits from the home screen.

Upcoming Webinars

- 4/6 3:00 PM EST
- 4/9 1:00 PM EST
- 4/10 10:00 AM EST

A recording of the TeleVisit webinar is now available.



Resources to Prepare for the Healthcare Business Impacts of COVID-19

- **The CARES Act**
  - Healthcare Provider Lost Revenue Grants
  - Payroll Protection Program
    - PPP Loan Forgiveness
  - Federal Loans (Businesses with 500 - 10,000 Employees)
  - Significant Tax Measures for Business
  - Unemployment Protection for Individuals
- **SBA Disaster Assistance**
- **IRS Federal Income Tax Deferral for 2019 Taxes**
- **Facebook Grants**
- **Convert Existing Accounts Receivables to Cash**
- **Medical AR Factoring**
- **Business Interruption Insurance**
- **The CMS Accelerated and Advanced Payments Program**

Questions?

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