Medicare and NY Medicaid Telehealth Changes During The COVID-19 PHE

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Better Healthcare Through Better Business

Agenda

- Terminology
- Condition Codes and Modifiers
- Medicare Telemedicine Reporting
- Medicaid Telemedicine Reporting
- Clinic E/M Coding
- Lab Services
- ICD-10 Coding Guidelines

Telemedicine/Telehealth

Terminology

- Terminology varies between publications and payers
- The Health Resources Services Administration definitions:
  - **Telehealth -** *The use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.*
  - *Telehealth … refers to a broader scope of remote healthcare services than telemedicine. Telehealth can refer to remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.*
  - **Telemedicine** - *Refers specifically to remote clinical services.*

  Source: https://www.healthit.gov/faq/what-telehealth-how-telehealth-different-telemedicine

Terminology – NGS Medicare University

- *What is available to Medicare Patients:*
  - *Telehealth Visits – audio and visual contacts*
  - *Includes patients at home*
- *Virtual services*
  - *Virtual check-in (phone contact)*
  - *Electronic review of images*
  - *E-Visits (electronic patient portals)*
  - *Telephone call*

Source: NGS, Medicare University, Medicare Updates Related to COVID-19 Billing, 4/14/2020

Terminology – NGS Medicare University

- **Telehealth** –
  - Must be audio and visual
  - Includes the 186 professional codes on the CMS web site
  - Distinct type of services that have traditionally been face-to-face
  - Still face-to-face except via audio/video connection
- **Telemedicine** –
  - Pay be provided to a patient without any physical patient contract
  - May be audio or email only
  - Includes the other services - E-visit, Virtual Check-in and Telephone Only

Source: NGS, Medicare University, Medicare Updates Related to COVID-19 Billing, Let's Chat, 4/15/2020

Originating Site

- Where the patient is located during the telehealth service
- During the PHE, includes patient's home
  - Q3014 with revenue code 780 **does not apply** when patient is at home
- *No originating site facility fee is billable/reimbursed when telehealth services are furnished under the waiver to beneficiaries located in places that were not identified as permissible originating sites prior to PHE*

Source: NGS, Medicare University, Medicare Updates Related to COVID-19 Billing, 4/14/2020

Distant Site

- Where the practitioner providing the service is located
- Pretty much any site that meets the standard criteria is allowed
- **Medicare:**
  - *Question: Can the distant site practitioner furnish Medicare telehealth services from their home? Or do they have to be in a medical facility?*
  - *Answer: There are no payment restrictions on distant site practitioners furnishing Medicare telehealth services from their home during the public health emergency. The practitioner should report the place of service (POS) code that would have been reported had the service been furnished in person. This will allow our systems to make appropriate payment for services furnished via Medicare telehealth which, if not for the PHE for the COVID-19 pandemic, would have been furnished in person, at the same [professional] rate they would have been paid if the services were furnished in person. New: 4/9/20*
  - Source: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

Distant Site

- **Medicaid:**
  - *C. **Distant Site** The distant site is any location including the provider's home that is within the fifty United States or United States' territories. The distant is the site where the telehealth provider is located while delivering health care services by means of telehealth. During the State of Emergency all sites are eligible to be distant sites for delivery and payment purposes including Federally Qualified Health Centers for all patients including patients dually eligible for Medicaid and Medicare. This includes clinic providers working from their homes or any other location during the State of Emergency.*
  - Source: https://www.health.ny.gov/health_care/medicaid/program/update/2020/docs/mu_n005_2020-03-21_covid-19_telehealth.pdf

Condition Codes and Modifiers

DR Condition Code

"Disaster Related"

Reported on institutional claims (technical 837I, CMS-1450)

Not discretionary

Mandatory for any claim for which Medicare payment is conditioned on the presence of a "formal waiver"

Needed to efficiently and effective process claims

Reported on both inpatient and outpatient claims

At the claim level when all the services/items are related to the emergency/disaster

Source: Chapter 38, Medicare Claims Processing Manual, Section 10

CR Modifier

- "Catastrophe/disaster related"
- Reported on Part B services for both institutional and non-institutional billing (837P, CMS-1500)
- Mandatory on applicable HCPCS codes for which Medicare Part B payment is conditioned on the presence of a "formal waiver"
- Appended to specific line-items/services on facility and professional claims related to the emergency/disaster.
  - E.g., patient is tested for COVID-19 and has a blood draw for a follow-up lab test on their hypercholesterolemia. The CR would only be reported on the COVID-19 testing.

Telehealth Billing and CR modifier and DR condition code

- MLN Matters, **SE20011 Revised**, April 10, 2020 – "Medicare FFS Response to the Public Health Emergency on the Coronavirus (COVID-19)"
- *Note: We revised this article on March 20, 2020, to add a note in the Telehealth section to cover the use of modifiers on telehealth claims and to explain the DR condition code is not needed on telehealth claims under the waiver. All other information is the same.*
- *As a reminder, CMS is not requiring the CR modifier on telehealth services.*
  - Source: https://www.cms.gov/files/document/se20011.pdf
  - FAQs: https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf
- This apparently includes just telehealth
- Telemedicine (virtual, e-visits and telephone) should be reported with CR modifier (and likely DR condition code)
  - Source: NGS COVID-News email, April 21, 2020

CS Modifier

- Source: CMS MLN Connects, Special Edition, April 7, 2020, https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-07-mlnc-se#_Toc37139913
- Families First Coronavirus Response Act
  - Waives cost-sharing (co-payment/deductible) under Medicare Part B for Medicare patients with COVID-19 testing-related services (U0001-U0004, or 87635)
  - These services are medical visits for the E/M categories:
    - Office and other OP services
    - Hospital observation services
    - Emergency department services
    - Nursing facility services
    - Domiciliary, rest home, or custodial care services
    - Home services
    - On-line digital E/M services

CS Modifier

- Waives cost-sharing to the COVID-19 testing-related medical visit services for which payment is made to:
  - HOPPS (APCs)
  - Medicare Physician Fee Schedule services
  - CAHs
  - RHCs
  - FQHCs
- For services furnished on March 18, 2020 through the end of the PHE:
  - Report the CS modifier on applicable claim lines to identify the service as subject to the cost-sharing waiver for COVID-19 testing
  - Rebill claims submitted for services after March 18 without the CS modifier to get 100% payment
- Additional information: https://www.cms.gov/files/document/se20011.pdf

Medicare Telehealth Modifiers

- GQ - Asynchronous "store and forward" technology is permitted only in Federal telemedicine demonstration programs conducted in Alaska or Hawaii
- GT – CAH Method II services
- Go (G zero) – Acute stroke diagnoses and treatment
- 95 - Service rendered was performed via telehealth during the current PHE

NY Medicaid Telehealth Modifiers

95 – For telehealth services with procedure codes listed in Appendix P of the CPT® manual

GT – For all other telehealth services where the procedure code is not listed in Appendix P

CMS Medicare Telemedicine Reporting

2% Sequestration Adjustment

- Section 3709 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act temporarily suspends the 2% payment adjustment currently applied to all Medicare Fee-For-Service (FFS) claims due to sequestration.
- The suspension is effective for claims with dates of service from May 1 through December 31, 2020.
- Source: MLN Connects, Special Edition, Friday, April 10, 2020

20% Increase for IPPS

- MLN Matter, SE20015, April 15, 2020
- Section 3710 of the CARES Act allows an 20% increase to DRG weighting factor for patients diagnosed with COVID-19 and discharged during the PHE
- Temporary adjustment applies an increased weighting factor to increase the MS-DRG relative weight/payment
- Must be coded with one of the following:
  - B97.29, *Other coronavirus as the cause of diseases classified elsewhere*, for discharges between January 27 – March 31, 2020
  - U07.1, *COVID-19*, for discharges after April 1, 2020

CMS Updates PTP Edits and MUEs Related to COVID-19 PHE

- Release from VitalWare™ Alert, April 16, 2020
  - CMS posted on 4/8/2020 an NCCI announcement that new PTP and MUE files would be released
  - The changes will be retroactive to January 1, 2020
  - Due to the expansion of telehealth services during the COVID-19 PHE, CMS is temporarily suspending:
    - Thousands of PTP edits for both hospitals and providers
    - And close to 200 MUE edits for both hospitals and providers
    - *Replacement Files (2nd quarter of 2020) – related to the COVID-19 Public Health Emergency: In accordance with Centers for Medicare & Medicaid Services' (CMS) expansion of telehealth services, CMS updated procedure-to-procedure (PTP) edits and Medically Unlikely Edits (MUEs) for Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes, retroactive to January 1, 2020*
    - Source: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd

CMS Telemedicine Under the PHE (Public Health Emergency)

- Released an initial set of coding and billing guidelines in early March
- Then released a much more extensive, and, in some cases, different set of coding and billing guidelines on March 30, 2020
- Primary document is the Interim Final Rule with Comment Period (CMS-1744-IFC) - https://www.cms.gov/files/document/covid-final-ifc.pdf
- The temporary guidelines apply to services starting on March 1, 2020 until the end of the PHE

Medicare Services

Four types of services as defined by Medicare:

1. Telemedicine (Telehealth) Services
2. Virtual Care
3. Telephone Services
4. E-Visits

Temporary Medicare Telehealth Changes

- **Geographic locations** – Both rural and non-rural HSRA areas may provide and bill
- **Originating sites** – Other locations can act as originating sites (where the patient is located) including home
- **Eligible providers** – Expanded the list of provider types eligible to provide telehealth services
- **Services** – Added more than 80 new codes (85) that may be provided via telehealth, not restricted to COVID-19 cases
- **Facility Fee** – Telehealth services provided under the waiver MAY NOT bill a facility fee (i.e., Q3014)

Temporary Medicare Telehealth Changes

- **FQHCs and RHCs not eligible as originating sites** – Temporarily they may be either originating or distant site
- **Critical Care consults limited to once per day** – Frequency limit waived
- **Provider location must be on enrollment application** – Providers may bill their usual location where they would see the patient if it was in person
- **Verbal consent is required before service is performed** – Consent should not interfere with the provision of telehealth services. Annual consent may be obtained at the same time as the services are furnished.

Medicare Telehealth Visits

- A visit with a provider that uses telecommunication systems between the provider and patient.
- May be provided by any technology with audio and video.
  - Two-way real-time interactive communication
  - Under the PHE allows Facetime, Skype…
  - Zoom is not suggested at this time
  - Opioid and Hospital allow audio only
- Under the PHE this service may be provided in either a rural or a non-rural area
- And the patient may be located anywhere, including their home

Medicare Telemedicine Services

- As of now, may only be provided by the following providers:
  - Physicians
  - NPs
  - PAs
  - Nurse-Midwives
  - CRNAs
  - *Clinical Psychologists
  - *LCSWs
  - Registered Dieticians
  - Nutrition Professionals

*These providers may only bill for psychotherapy services, not medical E/M

- CMS knows that other providers want to provide telemedicine services, including therapists
- CMS is taking this under advisement

Non-Eligible Medicare Distant Site Providers

- As of right now, the following cannot be paid by Medicare for telehealth services:
  - Physical therapists
  - Speech therapists
  - Occupational therapists
  - Chiropractors
  - Dentists
- CMS is considering changes

Medicare Telehealth Codes

- The list of current (including temporary codes) is available on: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
- 85 new codes have been temporarily added due to the PHE
- These include (e.g.):
  - ED visit codes (99281-99285)
  - Observation codes (99217-99220, 99224-99226, 99234-99239)
  - Hospital initial and discharge care codes (99221-99223, 99238-99239)
  - Critical care (99291-99292)
  - Therapy services (as provided by Telemedicine providers, not therapists)

Telehealth Services

- Billed to Medicare as professional services (only)
- Submitted with the appropriate CPT®/HCPCS codes
- Modifier – 95 is mandatory during the PHE
- Place of Service:
  - The one that is appropriate for the service as if the patient was seen face-to-face
  - (E.g., POS 11 – *Office*, POS 21 – *Inpatient*, POS 23 – *Emergency Department*)
  - No reduction in payment under MPFS
  - May bill POS 02 – *Telehealth*, however, the reimbursement will be at the lower facility rate
  - Institutional providers will report POS 19 or 22 and receive the lower facility rate
- CMS is apparently aware of this payment disparity and is investigating solutions

Place of Service for Telehealth

- Report the POS that would have been reported had the service been furnished in person
  - *Question: Can the distant site practitioner furnish Medicare telehealth services from their home? Or do they have to be in a medical facility?*
  - *Answer: There are no payment restrictions on distant site practitioners furnishing Medicare telehealth services from their home during the public health emergency. The practitioner should report the place of service (POS) code that would have been reported had the service been furnished in person. This will allow our systems to make appropriate payment for services furnished via Medicare telehealth which, if not for the PHE for the COVID-19 pandemic, would have been furnished in person, at the same rate they would have been paid if the services were furnished in person. New: 4/9/20*
  - Source: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

NGS Release April 15, 2020

- Proper Billing for Telehealth Services Claims:
  - A number of claims have been issued with both POS 11 – office and POS 2 – telehealth
  - The CMS-1500 paper form cannot contain more than one POS
  - One POS should be reported for telehealth:
  - "*If you are offering telehealth services as part of the PHE, those claims should be submitted with the POS from where the face-to-face service is normally performed (e.g., office POS 11, hospital POS 21) and include modifier 95 to identify this as a telehealth service during the PHE; this is the preferred method for submission.*"

Virtual Check-ins – G2010 / G2012

- Available since 2019, never followed the telehealth requirements (e.g., rural location)
- G2010 - *Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including 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*
- G2012 - *Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care 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 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*

Virtual Check-Ins – G2010 / G2012

- "Telecommunication"
  - Brief check-in via telephone or other telecommunication device (5-10 minutes)
  - Remote evaluation of recorded video and/or images
- Patient initiated, but patient may be "educated"
- May be provided in a variety of ways including audio/video, text messaging, email, telephone and patient portal
- During the PHE may be new or established patients
- Must have verbal consent, but may get it when service is furnished
- Coinsurance and deductible will apply
- Not telemedicine, do not need modifier - 95

Virtual Check-Ins – G2010 / G2012

- PHE temporary change
  - Have been designated as "sometimes therapy"
  - May be reported by private practice PT/OT/ST
  - Append GO, GP, GN modifier for therapy services
  - "*Further, to facilitate billing of the CTBS services by therapists for the reasons described above, we are designating HCPCS codes G2010, G2012, G2061-G2063 as 'sometimes therapy' that would require the private practice OT/PT/ST to include corresponding GO, GP or GN therapy modifier on claims for these services*"
- Source: https://www.cms.gov/files/document/covid-final-ifc.pdf
- Optometrists and Podiatrists can now provide these services
  - Medicare University Webinar, April 21, 2020

E-Visits – 99421-99423 & G2061-G2063

- Evaluation and Management:
  - 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 - *…; 11-20 minutes*
  - 99423 - *…; 21+ minutes*
- Assessments:
  - G2061- *Qualified nonphysician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes*
  - G2062 – *…; 11-20 minutes*
  - G2063 - *…; 21+ minutes*

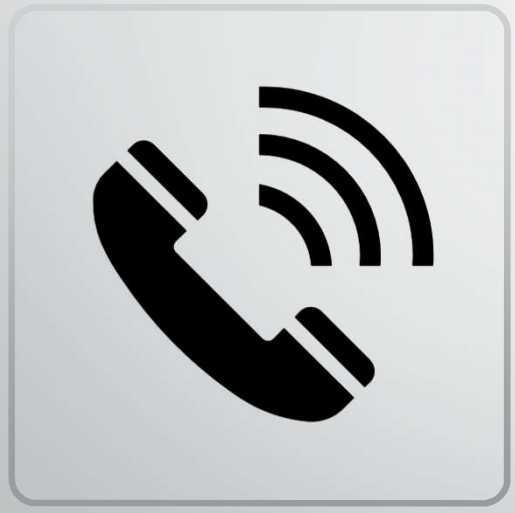
E-Visits – 99421-99423 & G2061-G2063

- These services are NOT considered telehealth
- Not telemedicine, do not need modifier - 95
- 99421- 99423 – Clinicians who may independently bill E/M services
- G2061-G2063 – Clinicians (PT/OT/ST, clinical psychologists) who may not independently bill for E/M
  - It appears that institutional therapists may bill and provide these services
  - Per NGS FAQs:
  - *Question: Can PT/OT/SLP providers perform and bill for telehealth?*
  - *Answer: No, PT and OT providers may not perform services via telehealth. PT/OT/SLP providers may perform E-visits (G2061-G2063) via patient portals, see the Medicare Telemedicine Health Care Provider Fact Sheet, which may be especially helpful to their patient communities during this healthcare emergency period.*

RHC and FQHC Billing – G0071 & E-Visits (99421-99423)

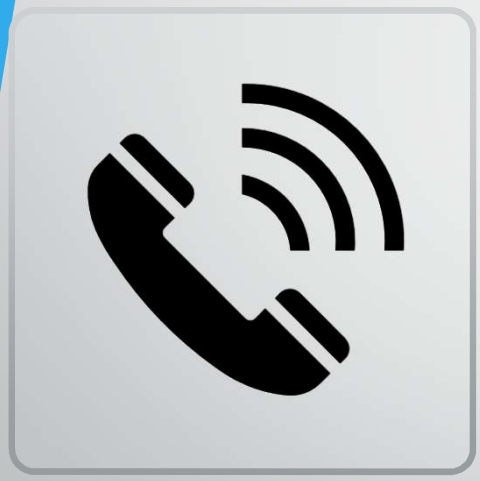
- **G0071 -** *Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only*
- Under the Waiver RHCs and FQHCs expanding services so that G0071 payment (new rate $24.76) includes addition of these services 99421-99423.
- Bill G0071 for services described by 99421-99423, do not bill 99421-99423.
  - New or established patients
  - Consent obtained when service is furnished
  - Consent may be acquired by staff under general supervision
  - Source: Medicare University

Telephone Only – 99441-99443 & 98966-98968



- Evaluation and Management:
  - 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*
  - 99442 - *...; 11-20 minutes of medical discussion*
  - 99443 - *...; 21-30 minutes of medical discussion*
- Assessment:
  - 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*
  - 98967 - *...; 11-20 minutes of medical discussion*
  - 98968 - *...; 21-30 minutes of medical discussion*

Telephone Only – 99441-99443 & 98966-98968



- Not telemedicine, no modifier – 95
- May be furnished by telephone or on-line
- One code set for providers that may bill E/M services (99441-99443)
- Another for qualified healthcare providers that may not bill E/M Services (98966 – 98968)

On-site Visits via Video or Through a Window

- *Question: Should on-site visits conducted via video or through a window in the clinic suite be reported as telehealth services? How could a physician or practitioner bill if this were telehealth?*
- *Answer: Services should only be reported as telehealth services when the individual physician or practitioner furnishing the service is not at the same location as the beneficiary. If the physician or practitioner furnished the service from a place other than where the beneficiary is located (a "distant site"), they should report those services as telehealth services. If the beneficiary and the physician or practitioner furnishing the service are in the same institutional setting but are utilizing telecommunications technology to furnish the service due to exposure risks, the practitioner would not need to report this service as telehealth and should instead report whatever code described the in-person service furnished. New: 4/9/20*
- Source: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

Medicare OTP (Opioid Treatment Programs)

- During the PHE, the counseling portion of the weekly bundled visits and add-on codes may be furnished using audio-only telephone
- All other applicable requirements must still be met

RHC and FQHCs

- New Updates Released – MLN Matters SE20016,April 17, 2020 https://www.cms.gov/files/document/se20016.pdf
- Requires interactive audio and video
- Practitioners may be anywhere, including their homes
- Practitioners may provide any telehealth service that is approved
- Payment for the distant site providers is set at $92
- Reported with modifier – 95 (January 27-June 30, 2020)
- Staring July 1, 2020 – Report with G2025 for telehealth services

NY Medicaid Telemedicine Reporting

Delay Reason 15 – Natural Disaster / State of Emergency

- Email April 16, 2020
- Claims that would have been required to be submitted during the State of Emergency exceeding the **timely filing limits**
- May be submitted electronically using **Delay Reason 15**
- Additional documentation does not need to be submitted (at this time)

Medicaid FFS (DOH) – Non-behavioral Health

- Primary site for updates: https://www.health.ny.gov/health_care/medicaid/program/update/2020/index.htm
- Two key documents:
  - Medicaid Update, Special Edition, Comprehensive Guidance Regarding Use of Telehealth including Telephonic Services During the COVI-19 State of Emergency, March 23, 2020 (been updated since then), Volume 36, Number 5, 3/31/2020, https://www.health.ny.gov/health_care/medicaid/program/update/2020/docs/mu_n005_2020-03-21_covid-19_telehealth.pdf
  - Frequently Asked Questions Regarding Use of Telehealth Including Telephonic Services During the COVID-19 State of Emergency, 3/31/2020, https://www.health.ny.gov/health_care/medicaid/covid19/docs/faqs.pdf

Key Components of Medicaid Update

- *"The intent of this guidance is to provide broad expansion for the ability of all Medicaid providers in all situations to use a wide variety of communication methods to deliver services remotely during the COVID-19 State of Emergency, to the extent it is appropriate for the care of the member.*
- *…*
- *This guidance relaxes rules on the types of clinicians, facilities, and services eligible for billing under telehealth rules.*
- *…*
- *This guidance replaces previously issued guidance regarding telehealth and telephonic communication services during the COVID-19 State of Emergency (Medicaid Update March 2020 Vol 36, Numbers 3 and 4)."*

II. Telephonic Reimbursement Overview

Payment for telephonic encounters for health care and health care support services will be supported in six different payment pathways utilizing the usual provider billing structure. See the table below for the billing pathways available for telephonic encounters during the COVID-19 State of Emergency by both FFS and Managed Care*: **Chart Changes in Bold 3/23/2/20**

Billing Lane	Telephonic Service	Applicable Providers	Fee or Rate	Historical Setting	Rate Code or Procedure	Notes:
Lane 1	Evaluation and Management Services	Physicians, NPs, PAs, Midwives, Dentists, RNs	Fee Schedule	Office	CPT Procedure Codes "99211", "99441", "99442", and "99443" "D9991" - Dentists	New or established patients. Append GQ modifier for 99211only
Lane 2	Assessment and Patient Management	All other practitioners billing fee schedule (e.g., Psychologist)	Fee Schedule	Office	Any existing Procedure Codes for services appropriate to be delivered by telephone. Append modifier GQ for tracking purposes.	Billable by Medicaid enrolled providers. New or established patients.
Lane 3	Offsite Evaluation and Management Services (non-FQHC)	Physicians, NPs, PAs, Midwives	Rate	Clinic or Other (e.g., amb surg, day program)	Rate Code "7961" for non-SBHC Rate Code "7962" for SBHC	New or established patients.
Lane 4	Offsite Evaluation and Management Services (FQHC)	Physicians, NPs, PAs, Midwives	Rate	Clinic	Rate Code "4012" **for non-SBHC** **Rate Code "4015" for SBHC**	New or established patients.
Lane 5	Assessment and Patient Management	Other practitioners (e.g., Social Workers, dieticians, **home care aides, RNs, therapists and other home care workers**)	Rate	Clinic or other **Includes FQHCs, Day Programs and Home Care Providers**	**Non-SBHC:** • Rate Code "7963" (for telephone 5 – 10 minutes) • Rate Code "7964" (for telephonic 11 – 20 minutes) • Rate Code "7965" (for telephonic 21 – 30 minutes) **SBHC:** • **Rate code "7966" (for telephone 5 – 10 minutes)** • **Rate code "7967" (for telephonic 11 – 20 minutes)** • **Rate code "7968" (for telephonic 21 – 30 minutes)**	Broadly billable by a wide range of provider types **including FQHCs, Day Programs and Home Care (e.g., aide supervision, aid orientation, medication adherence, patient check-ins). However, see LHCSA/CHHA assessments and RN visits which get billed under existing rates in Lane 6).** New or established patients. Report NPI of supervising physician as Attending.
Lane 6	Other Services (not eligible to bill one of the above categories)	All provider types (e.g., **Home Care**, ADHC programs, health home, **HCBS**, Peers, Hospice)	Rate	All other as appropriate	All appropriate rate codes as long as appropriate to delivery by telephone	Covers all Medicaid services not covered above. **Includes LHCSA and CHHA assessments, evaluations and RN visits.**

**Managed care plans may have separate detailed billing guidance but will cover all services appropriate to deliver through telehealth/telephonic means to properly care for the member during the State of Emergency. Further detail on FFS code coverage is provided below including links to specialized guidance for mental health, substance abuse and OPWDD services.*

Medicaid Telemedicine

May be provided by telephone only

Originating site (patient location) has no limits during the PHE, anywhere the patient is located

Distant site (provider location) must be within the 50 US states or territories, and may be in the provider's home.

Modifiers:

Modifier – 95 – codes in AMA's CPT® code book Appendix P

Modifier – GT – codes for which modifier – 95 is not applicable, i.e., codes not in AMA's CPT® code book

Telephonic Reimbursement and Billing

- **Lanes 1 and 2** pertain to private practice locations
- **Lanes 3 and 5** pertain to hospital-based Article 28 locations
- **Lane 4** pertains to FQHCs
- **Lane 6** pertains to other services (DOH to release more guidance in the future)
- Key definitions:
  - "Office" – Private Practices billed on a CMS-1500 and paid on the Medicaid Physician Fee Schedule
  - "Rate" – Hospital-based departments primarily billed with a rate code on a CMS-1450 (UB-04) and paid on APGs

Lanes 1 and 2 – Private Practice

Lane 1 –

- Private Practice
- Using telephone or audiovisual where patient is not in the office
- Billed with POS 11 on professional claim
- Reportable by Physicians, NPs, PAs, Nurse Mid-wives, Dentists, RNs
- **RNs** – Report 99211 with modifier GQ
- **Physicians, NPs, PAs and NMWs** – Report 99441-99443
- **Dentists** – Report D9991

Lane 2 –

- All other practitioners (e.g., licensed clinical psychologists)
- Report standard CPT®/HCPCS for the service with modifier GQ

Lanes 3 and 5 – Provider-Based Outpatient

General guidelines -

- Article 28/PBD
- Using telephone or audiovisual where patient is not in the office
- **Billed on a technical/facility claim only, no professional claim (even for physicians)**
- Report standard CPT®/HCPCS for the service
- Append modifier – 95 or – GT depending on the procedure code

Lane 3 –

- Reportable by Physicians, NPs, PAs, Nurse Mid-wives
- Rate code 7961 – non-school-based
- Rate code 7962 – school-based

Lane 5 –

- Other practitioners (e.g., social workers, dieticians, RNs, therapists)
- Rate code 7963-7965 (5-10min, 11-20min, 21-30min) – non-school-based
- Rate code 7966-7968 (5-10min, 11-20min, 21-30min) – school-based

Lanes 3 and 5 – Q & A

- According to email from DOH, Lanes 3 and 5 require an Admission Type
  - Admission Type = 1, emergency, if COVID-19- related
  - If not COVID-19 related report the same admission type usually reported for face-to-face
- Rate code 7961 – Upstate Rate = $ 64.97, Downstate Rate = $72.73
- Ancillary Policy Episodic Billing – **Not applied to Lanes 3 and 5**
  - All ordered tests should be billed as Ordered Ambulatory (no rate code)

OMH and OASAS

- General guidelines -
  - Articles 31 (OMH) and 32 (OASAS)
  - Using telephone or audiovisual where patient is not in the office
  - Billed on a technical/facility claim only
  - Report standard CPT®/HCPCS for the service
  - Report standard rate code
  - Append modifier – 95 or – GT depending on the procedure code
    - ***4. Should providers use the GT or 95 modifiers only when both audio and video telecommunications are used to provide services?***
    - *No. During the emergency disaster, providers must use the GT or 95 modifiers for either telephonic OR video provision of services, despite the modifier definitions requiring video.*
  - An excel file has been released providing specific CPT®/HCPCS codes and which modifier should be appended

Clinic E/M Coding Updates

Medicare/Medicaid – E/M Coding Change

- Interim CMS Final Rule – 3-26-2020
  - For **clinic/outpatient E/M telehealth encounters (99201-99215)**
  - Providers are allowed to use **MDM or Time** as the defining factor in selecting the appropriate E/M level of service
  - The new guidance effectively follows the planned 2021 clinic E/M guidance
  - If time is used, it is the total time associated with the service
  - Ruling is interim only and may be revoked after the crisis
    - *On an interim basis, we are revising our policy to specify that **the office/outpatient E/M level selection** for these services when **furnished via telehealth** can be **based on MDM or time**, with time defined as all of the **time associated with the E/M on the day of the encounter**; and to remove any requirements regarding documentation of history and/or physical exam in the medical record. This policy is similar to the policy that will apply to all office/outpatient E/Ms beginning in 2021 under policies finalized in the CY 2020 PFS final rule.*
    - Source: https://www.cms.gov/files/document/covid-final-ifc.pdf

Office Visits – Utilizing Time (2021 Guidelines)

- *"Physician/other qualified health care professional time includes the following activities:*
  - *Preparing to see the patient (e.g., review of tests)*
  - *Obtaining and/or reviewing separately obtained history*
  - *Performing a medically appropriate examination and/or evaluation*
  - *Counseling and educating the patient/family/caregiver*
  - *Ordering medications, tests, or procedures*
  - *Referring/communicating with other health care professionals (when not separately reported)*
  - *Documenting clinical information in the electronic or other health record*
  - *Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver*
  - *Care coordination (not separately reported)* "

Office Visits – Utilizing Time (2021 Guidelines)

- *"The typical times associated with the office/outpatient E/M's are available as a public use file at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F"*
- Source: **https://www.cms.gov/files/document/covid-final-ifc.pdf**

Office Visits – Utilizing Time (2021 Guidelines)

"After reviewing the RUC recommendations, in conjunction with the revised code descriptors and documentation guidelines for CPT codes 99202 through 99215, we believe codes and recommended values would more accurately account for the time and intensity of office/outpatient E/M visits than either the current codes and values or the values we finalized in the CY 2019 PFS final rule for CY 2021. Therefore, we proposed to establish separate values for Levels 2–4 office/outpatient E/M visits for both new and established patients rather than continue with the blended rate. We proposed to accept the RUC-recommended work and time values for the revised office/outpatient E/M visit codes without refinement for CY 2021."

Source: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F

TABLE 34: RUC-Recommended Pre-, Intra-, Post-Service Times, RUC-Recommended Total Times for CPT codes 99202-99215 and Actual Total Time

HCPCS	Pre-Service Time	Intra-Service Time	Immediate Post-Service Time	Actual Total Time	RUC-recommended Total Time
99202	2	15	3	20	22
99203	5	25	5	35	40
99204	10	40	10	60	60
99205	14	59	15	88	85
99211		5	2	7	7
99212	2	11	3	16	18
99213	5	20	5	30	30
99214	7	30	10	47	49
99215	10	45	15	70	70

Exams Via Telemedicine

- *Question: Some E/M services require performance of 3/3 elements (history, exam, MDM). May these services be performed via telehealth?*
- *Answer: Yes, these services may be performed via telehealth. As per CMS-1744-IFC, E/M selection may be based on MDM or time, and the requirement for documentation of a history and/or exam has been temporarily waived. Examination via telehealth is limited, but it is permissible for a provider to document pertinent observations such as skin color skin lesions/rashes, quality of respiration and evidence of wheezing or dyspnea, vital signs as reported by the patient. When this is done, these factors may also contribute to the level of coding.*
- Source: https://www.ngsmedicare.com/ngs/portal/ngsmedicare/newngs/home-lob/news-alerts/news-articles/news-detail/ngs%20telehealth%20billing%20faqs%20for%20covid-19/!ut/p/z1/1ZLbcoIwEIZfRR-A2SAR4mU4VCoC2g6l4YZhAJ3YEhyg2PbpDR2n9jDW6-Yms9l_v-yfLCTwClnIer7NOl6L7FnGLNFTTG8dVbWQFxIXIerZFNNgrpFIhQdgJrDXQNsFB4ivqROZRhcWRbI--ZCcCVpIEMU3pm2vV9rcnJwEfzCY7MG42IOqQtzz8gCRqJtKGrwfiLHlp-vIuZO1YtsuQ-loITXdSO7LoALmcyHKtu6yU_770e6l4W3B8-HJgC2-RCN9AJxp8qp9zgtgOsKbEuuFMpsSrOBJniskI4ViGLOc6DohhVGCe9WM9n_MLH587K_RiK3PMUpU2FfiTXna-M6BUrdKbdOn1Jz27x4dj4-Ofuib/dz/d5/L2dBISEvZ0FBIS9nQSEh/?ngsLOB=Part%20B&LOC=Minnesota&ngsLOC=Minnesota&jurisdiction=Jurisdiction%206&LOB=Part%20B

Well Visit Codes by Telemedicine

- CMS says that the requirements have not changed
- Some requirements may be difficult to obtain when the patient is at home
- CMS has received this question and is taking it under advisement
- Changes may be forthcoming
- NGS Medicare University "Let's Chat" – April 15, 2020
  - May obtain some vitals (e.g., BP, weight, height) from the patient. Document how these vitals were obtained.

Telehealth Documentation Requirements

- *Same as any face-to-face patient encounter, with following additions:*
  - *A statement indicating the service was provided via telemedicine:*
    - *Patient location*
    - *Provider location*
    - *Names of all persons participating in the telemedicine service and their role in the encounter*
  - *For time-based services, include the clinical or physician time relative to the encounter*
    - *Document start and stop time or total time*

Source: NGS, Medicare University, Medicare Updates Related to COVID-19 Billing, 4/14/2020

Teaching Physicians

- Supervision may be in person or via interactive telecommunication during key portions of the service
- All levels of E/M in primary care centers under the primary care exception may be provided under direct supervision or telecommunication

Lab Reporting Updates

Lab Test Codes

HCPCS	Desc	Type	SI/APG	Rev Code Suggestion	Medicare/ Medicaid	NGS Fee	NYS Medicaid APG	Lab fee schedule	APG ancillary packaged	If stand alone do not pay	Effective dates
U0001	CDC 2019 novel Coronavirus (2019-nCoV) real-time RT-PCR diagnostic panel	New Medicare code	A	300	Medicare/ Medicaid and HMO	$35.91	APG 397 weight=0.2393	not in fee schedule	not packaged	no	Effective April 1, 2020, for DOS on or after February 4, 2020
U0002	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC	New Medicare code	A	300	Medicare/ Medicaid and HMO	$51.31	APG 396 weight=0.0604	$51.31	packaged ancillary	no	Effective April 1, 2020, for DOS on or after February 4, 2020
87635	Infectious agent detection by nucleic acid, COVID-19, amplified probe technique	New CPT code	A	306	Medicare/ Medicaid and HMO	considered same as U0002 for pricing 51.31	APG 397 weight=0.2393	$51.31	not packaged	no	Effective April 1, 2020, for DOS on or after March 13, 2020

Two new HCPCS codes for High-Production Coronavirus Lab Tests

HCPCS	Desc	Type	SI/APG	Rev Code Suggestion	Medicare/ Medicaid	NGS Fee	Effective dates	Notes
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.	New Medicare code		306		CMS fee $100	effective April 14, 2020	High-throughput technologies-- High-throughput lab tests can process more than two hundred specimens a day using highly sophisticated equipment that requires specially trained technicians and more time-intensive processes to assure quality.
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	New Medicare code		300		CMS fee $100	effective April 14, 2020	High-throughput lab tests can process more than two hundred specimens a day using highly sophisticated equipment that requires specially trained technicians and more time-intensive processes to assure quality. https://www.cms.gov/files/document/cms-2020-01-r.pdf. High-throughput technologies

G2023	Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source	New Medicare code			Not billable by hospitals	Reportable by Medicare-enrolled independent laboratories
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	New Medicare code			Not billable by hospitals	Reportable by Medicare-enrolled independent laboratories

Specimen Collection

Specimen Handling

HCPCS	Desc	Type	SI/APG	Medicare / Medicaid	NGS Fee	NYS Medicaid APG	Lab fee/APG ordered by Amb schedule	APG ancillar packaged	If stand alone do not pay	Effective dates	Notes
99000	Handling and/or conveyance of specimen for transfer from the office to a laboratory	Medicaid	APG=304	Medicaid only	none	APG weight=0.2172	not in fee scheduled	not package d	no	Added 1/1/2020	APG created 1/1/2020 (before covid crisis) probably charge if only service provided
99001	Handling and/or conveyance of specimen for transfer from the patient in other than an office to a laboratory (distance may be indicated)	Medicaid	APG=304	Medicaid only	none	APG weight=0.2172	not in fee scheduled	not package d	no	Added 1/1/2020	APG created 1/1/2020 (before covid crisis) probably charge if only service provided

Nurse-only E/M

E.g., Emergency Room- tent specimen collection

- 99211- Nurse-only defined by hospital acuity levels?
  - Consider reporting if only service reported and no other E/M service provided for DOS and it meets the guidelines for a 99211

HCPCS	Desc	Notes
99211	Nurse only throat swab	Included in hospital E/M acuity coding guidelines? Technical billed on UB. Maps to G0463.

New CPT Codes for Ab Testing

HCPCS	Desc	Type	SI/APG	Rev Code Suggestion	NGS Fee	Effective dates	Notes
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])	New CPT code	?	302	?	Valid 4/10/2020	(For severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [Coronavirus disease {COVID-19}] antibody testing using single step method, use 86328)
86769	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])	New CPT code	?	302	?	Valid 4/10/2020	(For severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [Coronavirus disease {COVID-19}] antibody testing using multiple-step method, use 86769)

https://www.ama-assn.org/system/files/2020-04/cpt-assistant-guide-coronavirus-april-2020.pdf

Blood test

CS Modifier

Cost Sharing modifier is not needed for lab test codes

Labs already have no copay or deductible

Diagnosis Coding

Inpatient

Code with one of the following:

- **B97.29**, *Other coronavirus as the cause of diseases classified elsewhere*, for discharges between **January 27 – March 31, 2020**
- **U07.1**, *COVID-19*, for discharges **after April 1, 2020**

- Section 3710 of the CARES Act allows an 20% increase to DRG weighting factor for patients diagnosed with COVID-19 and discharged during the PHE
- Temporary adjustment applies an adjustment factor to increase the MS-DRG relative weight

Outpatient
ICD-10-CM Official Coding Guidelines

- Coding Guidelines **4/1/2020 – 9/30/2020**
  - Code only confirmed cases based on provider's documentation
  - Presumptive positive should be coded as confirmed
    - U07.1, *COVID-19*
    - U07.1 is primary
  - Suspected cases should be coded to the reason for encounter
    - E.g., Z20.828, *contact with / exposure to viral communicable diseases*
    - Source: https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf

General Guidance

- Pneumonia
  - For a pneumonia case confirmed as due to the 2019 novel coronavirus (COVID-19), assign codes U07.1, *COVID-19*, and J12.89, *Other viral pneumonia*.
- Acute Bronchitis
  - For a patient with acute bronchitis confirmed as due to COVID-19, assign codes U07.1, and J20.8, *Acute bronchitis due to other specified organisms*.
  - Bronchitis not otherwise specified (NOS) due to COVID-19 should be coded using code U07.1 and J40, *Bronchitis, not specified as acute or chronic*.

General Guidance

- Lower Respiratory Infection
  - If the COVID-19 is documented as being associated with a lower respiratory infection, not otherwise specified (NOS), or an acute respiratory infection, NOS, codes U07.1 and J22, *Unspecified acute lower respiratory infection*, should be assigned.
  - If the COVID-19 is documented as being associated with a respiratory infection, NOS, codes U07.1 and J98.8, *Other specified respiratory disorders*, should be assigned.

General Guidance

- ARDS
  - For acute respiratory distress syndrome (ARDS) due to COVID-19, assign codes U07.1, and J80, *Acute respiratory distress syndrome*.

General Guidance

- Exposure to COVID-19
  - For cases where there is a concern about a possible exposure to COVID-19, but this is ruled out after evaluation, assign code Z03.818, *Encounter for observation for suspected exposure to other biological agents ruled out*.
  - For cases where there is an actual exposure to someone who is confirmed or suspected (not ruled out) to have COVID-19, and the exposed individual either tests negative or the test results are unknown, assign code Z20.828, *Contact with and (suspected) exposure to other viral communicable diseases*.
  - If the exposed individual tests positive for the COVID-19 virus, see guideline a).

General Guidance

- Screening for COVID-19
  - For asymptomatic individuals who are being screened for COVID-19 and have no known exposure to the virus, and the test results are either unknown or negative, assign code Z11.59, *Encounter for screening for other viral diseases*.

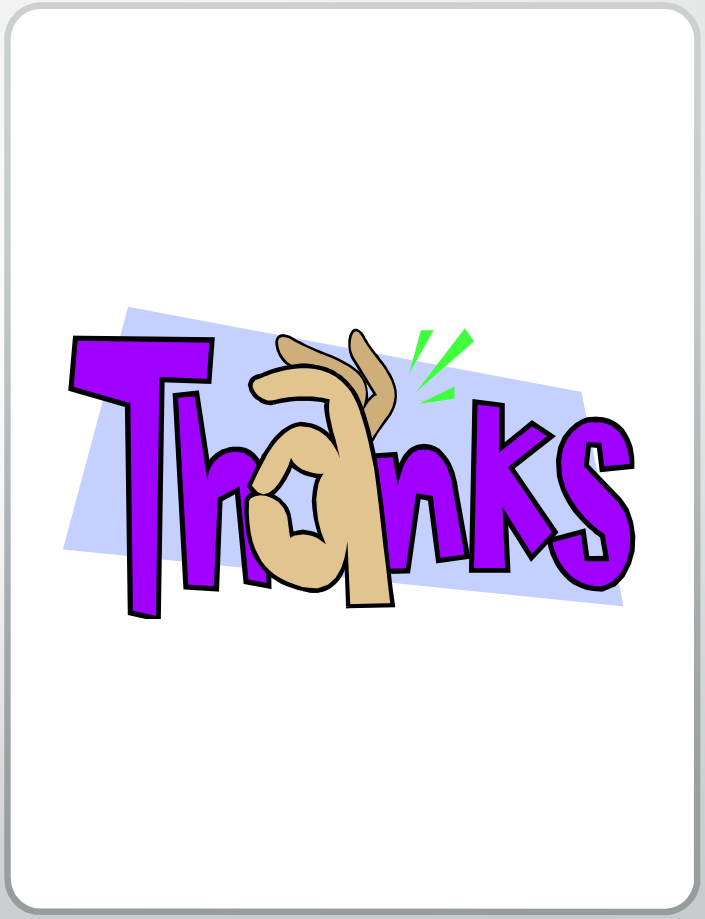
General Guidance

- Signs and symptoms
  - For patients presenting with any signs/symptoms associated with COVID-19 (such as fever, etc.) but a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms such as:
    - R05 *Cough*
    - R06.02 *Shortness of breath*
    - R50.9 *Fever, unspecified*
  - If a patient with signs/symptoms associated with COVID-19 also has an actual or suspected contact with or exposure to someone who has COVID-19, assign Z20.828, *Contact with and (suspected) exposure to other viral communicable diseases, as an additional code*.
  - This is an exception to guideline I.C.21.c.1, Contact/Exposure.

General Guidance

- Asymptomatic individuals who test positive for COVID-19
  - For asymptomatic individuals who test positive for COVID-19, assign code U07.1, *COVID-19*.
  - Although the individual is asymptomatic, the individual has tested positive and is considered to have the COVID-19 infection.

Questions and Discussion



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