COVID-19 Interim Final Rule Overview Q&A Session

As you all are well aware, the information coming from CMS during the public health emergency is faster than a speeding bullet. It often feels like information overload and what is guidance today can fast become yesterday's news. So, with that caveat out of the way, I will delve into the most asked questions.

We are still getting a lot of questions related to what can hospitals bill for telehealth services. We realize this can be confusing for hospitals since this information is so new and it is being released at an unprecedented speed by CMS, however, there is still nothing new that hospitals can bill under these circumstances.

Telehealth services are still professional services billable on professional claims – 1500 claim forms under the approved provider's NPI.

Originating site fee: Q3014 may still be submitted by hospitals on UB04 claims, all existing rules related to the code are still in place:

- The patient must be physically present at your location;
- They must be receiving a covered telehealth service from an approved telehealth provider; and
- The telehealth provider must be physically located at a separate distant site.

We also had several lab related questions come through. A general observation is that there may be some confusion on whether the CS modifier should be added to a Covid lab test. Clinical Diagnostic Lab tests do not have any cost sharing associated with them, therefore the CS modifier would not be needed on these codes. I hope that clears up some of the misunderstanding.

Lab Questions

If Covid was a send out test, example to Quest, would we use new code U0003 or U0004 for these send out tests?

The lab test to bill depends upon the actual lab test ordered. U0003 and U0004 are to be used for testing that utilizes high throughput technology. The differentiation between the 2 codes is that U0003 is to be used for testing that is done by amplified probe technique otherwise reported with 87635. U0004 would be used for all other methodologies. It is important to also understand from your reference lab what CPT/HCPCS codes they are billing you since you should be billing the patient the same tests the reference lab is billing you.

If hospital lab staff travels to a patient's house that is not home bound to collect labs, Can the hospital charge for the phlebotomy charge?

In order to be able to charge for a collection fee, the patient would need to be homebound.

Has there been any talk about AMA creating a CPT code for high throughput PCR testing?

No announcement on this from the AMA that we are aware of at this time.

There were several questions related to the specimen collection codes G2023 and G2024 in various settings such as in tents at hospital locations or drive through testing.

The written guidance on billing G2023 has not changed. The patient would need to be considered homebound and the lab technician would have to physically go to the home or SNF and actually collect the specimen in order to bill for these codes.

However, on the CMS Office Hours call last evening, a CMS representative, Tiffany Swaggert stated that hospitals could bill for this code. She did not elaborate on that statement. The April release of the OCE (Outpatient Code Editor) did assigned status indicator N to these codes. And from a hospital perspective that means this code is packaged into other services on the claim.

But we caution everyone that there still is no official written guidance that changes the original intent of these collection codes that was explained in the Interim Final Rule and the CMS Claims Processing Manual Chapter 17.

Has CMS stated what they will reimburse for covid-19 antibody testing?

Based on the CMS call yesterday, CMS had not yet addressed the reimbursement for the antibody testing codes that have recently been released. CMS stated they are working on it and will be releasing that information as soon as possible. CMS also said facilities could hold those claims until the reimbursement information is released. Additionally, we have not seen any official guidance on these codes at all yet.

Can we retroactively bill cases utilizing high throughput technology (U0003 and U0004)?

The CMS Rule 2020-010R release April 14, 2020, talks about the clinical diagnostic lab tests administered during the ongoing emergency period beginning on or after March 18, 2020. It further goes on to define the actual lab tests by code 87635 or U0002 and U0003 or U0004 shall be paid at the rate of $100.

On the CMS call last night when asked this question, the CMS representative stated that U0003 and U0004 are billable starting April 14, 2020, which is the effective date as stated in the ruling

This was confusing and conflicting information. But we refer you back to what is in writing in the CMS Ruling since this is the written guidance.

Coding Questions

19 by ED doctor based on chest x-ray without laboratory testing, and never had laboratory testing before, can we code U07.1? Patient had fever and shortness of breath. Should we code fever and shortness of breath for this ED visit, and not to code U07.1?

The CDC guidance states: link on landing page…
https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf

CS Modifier Questions

We also received several questions related to the CS modifier and there were several questions on the CMS call last night that addressed this issue.

People were interested in knowing if the CS modifier should be added to testing services that are related to COVID 19 diagnosis, such as CT scans and CXRs. The CMS representative stated the guidance is as it stands in the regulation

and the providers should not be holding up claims. The CS modifier should be appended to the evaluation and management codes on the claim. Another caller asked if the modifier should be added to the lab code and the answer was there is no cost sharing related to the clinical lab fee schedule so the CS modifier would not pertain to lab tests.

Should CS modifier be applied to a CT Scan?

The current guidance which was reiterated on the CMS call last night is that the CS modifier would be appended to the physician evaluation and management CPT code only. The CMS representative said they would continue to look into this, however, claims should be submitted under the current guidance.

To clarify, if a patient presents with possible COVID signs and symptoms, but the physician does NOT order COVID testing, we would still apply CS modifier to the E&M services?

Per the CMS bulletin, for claims with dates of service on or after March 18th 2020 the "CS" modifier may be appended to evaluation and management services;

- That result in an order for or administration of a COVID-19 test,
- Are related to furnishing or administering such a test, or
- Are rendered for purposes of determining the need for such a test

Even if the test is not ordered but was evaluated for the test and that was documented you could apply CS modifier.

Is it appropriate to bill Modifier CS and CR on the same charge/claim line?

We would need more information in order to be able to accurately answer this question.

Can the CS modifier be used if the patient renders only a COVID lab test and no E/M level?

The clinical Lab fee schedule does not have cost-sharing therefore the CS modifier would not be needed on a lab test.

Does the CS modifier apply to both the professional bill AND the technical bill for the same service? IE: Patient in ED with COVID symptoms. Do we apply CS to Pro E&M and Tech E&M?

Yes, the CS modifier would be appropriate for both the professional claim and the facility claim for this scenario if there was an order for a COVID test.

Telehealth Questions

For Cardiologists, is remote monitoring covered as Telehealth? Provider billed 93295,93296 in POS 02, which denied. Would it be appropriate to bill 93295,93295 in POS 11 with 95 modifier? Patient seen via video, E.M billed POS 11 with -95 modifier

CPT codes 93295 and 93296 are not on the list of covered telehealth codes so these codes will not be reimbursed under the telehealth waivers. Remote monitoring is not a telehealth service.

Can 98966-98968 be billed and reimbursed to/from Medicare on a 1500 for provider based clinics?

Yes, the services can be billed on a 1500 to capture the professional work for providers in the clinic but again there would be no facility/technical charge.

Can hospitals, other than CAH or Rural health bill for telehealth on UB-04 or is this pro fee billing only?

The only approved code for facility billing for telehealth services at this time continues to be the Q3014. On each CMS call providers ask this question and they are getting the same answer which is that CMS is looking into it.

Can G2010-G2012 and G2061-G2063 be billed by PT/OT/ST on UB04?

These codes are professional codes only and at the present time cannot be reported on a UB04.

If a claim is submitted with the POS of 02, will it deny?

The guidance says that providers can continue to report place of service 02, however, this will in payment at the lower facility rate.

Accelerated Payments Questions

How are the offsets going to be identified on the remittances? How will we know whether it is due to the accelerated versus other take backs?

There should be information on the remittance advice that will identify it as an accelerated take back. On the CMS call last night the representative said they did not know what that messaging will be yet so stay tuned.

For the Medicare repayment of advanced payment, what if the hospital is a PIP provider. will they do off sets from the PIP payments?

As stated in the CMS fact sheet: For the small subset of Part A providers who receive Period Interim Payment (PIP), the accelerated payment reconciliation process will happen at the final cost report process (180 days after the fiscal year closes).

Miscellaneous Questions

CMS seemed to indicate that the current CPT typical times OR the 2021 E/M typical times could be used. Do you agree that using the 2021 times is best practice?

This is up to provider preference. CMS is giving providers the option to use the new "defined times" which will be implemented in 2021, however if you already have billing systems/EMR tools that base code selection on the current guidelines for 2020 these can continue to be used as well.

Is Medicare waiving the deductible and co-pays/coinsurance?

When there is a need to apply the CS modifier, the CMS bulletin states providers should not charge Medicare beneficiaries any co-insurance and/or deductible amounts for these services. Lab tests already do not have.

DR Condition Code and CR Modifier

There were a couple of questions asking about the DR condition code and the CR modifier.

The DR condition code and the CR modifier are confusing. When researching the DR condition code, it was developed initially to deal with natural disasters that affected a specific geographic area like the gulf coast oil spill. It was most likely not intended for a pandemic whereby every state in the country would be affected. There are many, many waivers that have been issued during this pandemic, blanket waivers, state specific waivers, state specific Medicaid waivers. There is an entire page on the CMS website dedicated to waivers.

But to get a little more specific: CMS states the Use of the DR condition code will be mandatory for any claim for which Medicare payment is conditioned on the presence of a "formal waiver. It is only used for institutional billing and is used at the claim level when all of the services/items billed on the claim are related to the emergency/disaster.

It is not diagnosis code related, its use is dependent upon care rendered under an actual waiver.

The CR modifier is line item specific and is mandatory for applicable HCPCS codes on any claim for which Medicare Part B payment is conditioned, again, on the presence of a "formal waiver,".