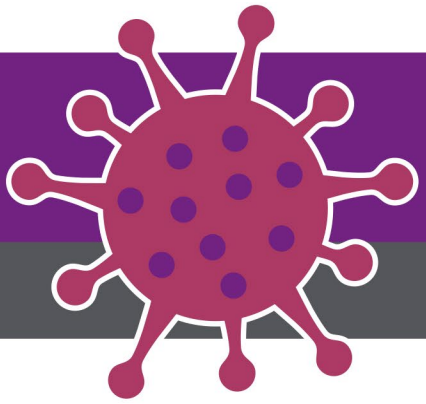
CORONAVIRUS DISEASE 2019
(COVID-19)

CMS Billing Guidance under Waivers, MLN Article SE20011 Updated 7/30/2020



Trinity Health

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On March 16, 2020, CMS released MLN Matters article, SE20011, with subsequent revisions on March 18, 19, 20, April 10, June 6, 19, 26, July 1, 8,17, 24, 28 and 30, 2020. The purpose of the CMS article is to provide guidance and instructions to providers billing under 1135 and 1812 (f) waivers issued by the federal government in response to the COVID-19 pandemic. The waivers are designed to temporarily relax certain regulatory provisions in order to promote access to healthcare during crises.

This SE article initially contained information only related to use of condition code DR and modifier CR as described below. The April 10th update includes guidance on several other topics.

Billing for Professional Telehealth Services During the Emergency

Through the Interim Final Rule published on March 31, 2020, CMS provided information on use of modifier 95, updated the list of telehealth services and provided guidance on which place of service codes should be used for telehealth services provided during the Public Health Emergency (PHE). This SE article includes this information. This has already been communication by System Office through the following COVID-19 Communication: COVID-19 Interim Final Rule 2020

- Use modifier 95 to indicate the service was performed via telehealth
- Use Place of Service (POS) equal to what it would have been had the service been furnished in-person
- Use modifier GO for services furnished for diagnosis and treatment of an acute stroke
- Use modifier GT for critical access hospital method II institutional claims

This article also includes a link to a video CMS created that provides answers to many common telehealth questions: https://www.youtube.com/watch?v=bdb9NKtybzo&feature=youtu.be

Medical Education Updates

Teaching physicians and residents: Expanded use of CPT codes that may be billed with the GE modifier under 42 CFR 415.174 on and after March 1, 2020, for the duration of the public health emergency:

• Residents furnishing services at primary care centers may provide an expanded set of services to beneficiaries
• Services are CPT codes 99204-99205, 99214-99215, 99495-99496, 99421-99423, 99452, and 99441-99443 and HCPCS codes G2010 and G2012
• Teaching physicians may submit claims for these services furnished by residents in the absence of a teaching physician using the GE modifier

Medicare Administrative Contractors will automatically reprocess claims billed with the GE modifier on or after March 1, 2020, that were denied. You do not need to do anything.

Coverage of Counseling Services and COVID-19 Testing:

CMS has added additional coverage for patient counseling services as part of the evaluation and management services provided in conjunction with beneficiary testing for COVID-19. Counseling services should consist of the importance of self-isolation, despite symptoms or quarantining while awaiting test results. Providers should encourage their patients to follow-up with public health officials, ensure they encourage dialogue with patient close contacts and participate in contact tracing.

- Many additional resources are available to providers, including checklists, handouts for patients and CDC resource lists. These tools are available via links within SE20011. There are also additional resources located on the Trinity Health COVID-19 Pulse page. Physician Reimbursement, COVID Counseling

Guidance on Use of CS Modifier

CMS waives co-insurance on COVID-19 testing and any evaluation & management visit that results in an order or performance of COVID-19 testing. The details around this has been communicated through the following: Coinsurance Deductible Waiver for Testing Related E&Ms and Use of CS Modifier

Expanded Use of Ambulance Origin/Destination Modifiers

During this PHE, Medicare will cover a medically necessary emergency and non-emergency ground ambulance transportation from any point of origin to a destination that is equipped to treat the condition of the patient consistent with state and local Emergency Medical Services (EMS) protocols where the services will be furnished. On an interim basis, CMS is expanding the list of destinations that may include but are not limited to:

- Any location that is an alternative site determined to be part of a hospital, Critical Access Hospital (CAH), Skilled Nursing Facility (SNF)
- Community mental health centers
- Federally Qualified Health Centers (FQHCs)
- Rural health clinics (RHCs)
- Physicians' offices
- Urgent care facilities
- Ambulatory Surgery Centers (ASCs)
- Any location furnishing dialysis services outside of an ESRD facility when an ESRD facility is not available
- Beneficiary's home

CMS expanded the descriptions for these origin and destination claim modifiers to account for the new covered locations:

- Modifier D - Community mental health center, FQHC, RHC, urgent care facility, non-provider-based ASC or freestanding emergency center, location furnishing dialysis services and not affiliated with ESRD facility
- Modifier E – Residential, domiciliary, custodial facility (other than 1819 facility) if the facility is the beneficiary's home
- Modifier H - Alternative care site for hospital, including CAH, provider-based ASC, or freestanding emergency center
- Modifier N - Alternative care site for SNF
- Modifier P - Physician's office
- Modifier R - Beneficiary's home

New Specimen Collection Codes

The Interim Final Rule noted above also provided for two new COVID-19 specimen collection codes. However, these codes are only for use by independent laboratories that travel to collect the specimens from homebound and other facility inpatients. At this time, these codes cannot be used by hospitals.

Hospitals may report HCPCS Code C9803 for COVID-19 Specimen Collections.

Provider Offices may report 99211 for specimen collection.

Beneficiary Notice Delivery Guidance

CMS provided information on alternative methods for delivering beneficiary notices. The details around this have been communicated through the following: CMS Beneficiary Notice Alternative Delivery Methods

Condition Code DR and Modifier CR

Two claims identifiers are to be used when billing for services provided to Medicare beneficiaries have been impacted by or fall under exceptions or expanded provisions under the waivers.

1. Condition code “DR” (disaster related) for institutional billing, i.e., claims submitted using the ASC X12 837 institutional claims format or paper Form CMS-1450.

2. Modifier “CR” (catastrophe/disaster related) for Part B billing, both institutional and non-institutional, i.e., claims submitted using the ASC X12 837 professional claim format or paper Form CMS-1500 or, for pharmacies, in the NCPDP format.

Acute Care Hospitals

The blanket waiver allows IPPS hospitals to house acute care inpatients in excluded distinct part units, where the distinct part unit’s beds are appropriate for acute care inpatient.

- The IPPS hospital should bill for the care
- Annotate the patient’s medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to the emergency.

Bill with condition code DR on UB-04 claims when acute care patients are housed in Excluded Distinct Part Units due to capacity management. Examples:

- A patient requiring general medical care may be housed in an inpatient rehabilitation unit without receiving or requiring inpatient rehabilitation services.
- A patient requiring intensive care on a ventilator, may be housed in the emergency department as an inpatient, because of the availability of equipment and staff

Bill with condition code -DR on UB-04 claims when remote outpatient hospital service are being provided to patients in their homes or other temporary relocation sites.

Telehealth Providers

This SE article clarifies that telehealth services provided under these waivers DO NOT need to append the modifier -CR or condition code DR to their claims.

Starting March 6, 2020, Medicare can pay for office, hospital, and other visits furnished via telehealth across the country and including in patient’s places of residence. A range of providers, such as doctors, advanced practice providers, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth, virtual check-ins and e-visit services, without restriction to place or setting for providing telehealth services to Medicare Beneficiaries as a result of the Emergency

The HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs. For all cost-sharing instruction, refer to Trinity Guidance from http://www.trinity-health.org/workfiles/covid-19-testing-co-payments-and-deductibles.pdf

TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/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-general-information/telehealth/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 an established patient.	HCPCS code G2012 HCPCS code G2010	For established patients
E-VISITS	A communication between a patient and their provider through an online patient portal	• 99421 • 99422 • 99423 • G2061 • G2062 • G2063	For established patients

Please follow pre-existing CMS instructions for the following telehealth services:

- In cases when a telehealth service is furnished via asynchronous (store and forward) technology as part of a federal telemedicine demonstration project in Alaska and Hawaii, the GQ modifier is required.
- When a telehealth service is billed under CAH Method II, the GT modifier is required.
- Finally, when telehealth service is furnished for purposes of diagnosis and treatment of an acute stroke, the G0 modifier is required.

Skilled Nursing Facility

Starting on July 6, 2020, and for the duration of the public health emergency, consistent with sections listed below of CDC guidelines titled, “Interim SARS-CoV-2 Testing Guidelines for Nursing Home Residents and Healthcare Personnel,”

Diagnostic Testing

- Testing residents with signs or symptoms of COVID-19
- Testing asymptomatic residents with known or suspected exposure to an individual infected with SARS-CoV-2, including close and expanded contacts (e.g., there is an outbreak in the facility)
- Initial (baseline) testing of asymptomatic residents without known or suspected exposure to an individual infected with SARS-CoV-2 is part of the recommended reopening process
- Testing to determine resolution of infection

Original Medicare and Medicare Advantage Plans don’t cover non-diagnostic tests.

The blanket waiver allows:

- For relaxing of the 3-day prior hospitalization requirement for coverage of a SNF stay providing temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of disaster or emergency.
- For certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period; if the patient is affected by the emergency. See SE20011 for examples of applicability.

For admission under the benefit period waiver:

- Complete a 5-day PPS Assessment. (The interrupted stay policy does not apply.)
- Follow all SNF Patient Driven Payment Model (PDPM) assessment rules.
- Include the HIPPS code derived from the new 5-day assessment on the claim.
- The variable per diem schedule begins from Day 1.

Bill with Condition Code DR on UB-04 claims when billing under the allowances noted above. Examples:

- Patient has been treated as an inpatient for one night, can be transferred to a skilled nursing home on day two and their skilled nursing facility stay will be covered by Medicare, as long as the patient was transferred, relocated or evacuated for capacity management purposes at the acute care facility needing inpatient beds.
    - Condition code DR - identifies the claims as related to the PHE
    - Condition code 57 (readmission) - this will bypass edits related to the 3-day stay being within 30 days
    - COVID100 in the remarks - this identifies the claim as a benefit period waiver request.
- Benefit periods are renewed for patients that have recently exhausted Part A benefits
    - Submit a final discharge claim on day 101 with patient discharge status 01
    - Readmit the beneficiary (Day 101) to start the benefit period waiver

NOTE: If a claim that was previously submitted and was rejected or denied, please refer to SE20011 for specific instructions for reprocessing.

Due to manual claims processing procedures in place, please allow additional time for claims submitted to the MAC.

For continued coverage in exhausted benefits scenarios, facilities must:

Track benefit days used in the benefit period waiver spell and only submit claims with covered days 101 - 200.

- Once the additional 100 days have been exhausted, follow existing processes to continue to bill Medicare no-pay claims until you discharge the beneficiary.
- Identify no-pay claims as relating to the benefit period waiver by using condition code DR and including “BENEFITS EXHAUST” in the remarks field.

Continuous coverage for SNF care that is routine and not affected by the pandemic, is not subject to Waivers.

In making such determinations, a SNF resident’s ongoing skilled care is considered to be emergency-related *unless* it is altogether unaffected by the COVID-19 emergency itself (that is, the beneficiary is receiving the very same course of treatment as if the emergency had never occurred). This determination basically involves comparing the course of treatment that the beneficiary has actually received to what would have been furnished *absent* the emergency. Unless the two are exactly the same, the provider would determine that the treatment has been affected by – and, therefore, is related to – the emergency.

• Providers should use the above criteria in determining when to document on the claim that the patient meets the requirement for the waiver.

In this situation, we would also ask those providers to work with their respective MACs to provide any documentation needed to establish that the COVID-19 emergency applies for the benefit period waiver under §1812(f) for each benefit period waiver claim.

- During the COVID-19 PHE, some SNF providers may have not yet submitted the PPS assessments for the benefit period waiver. In these limited circumstances, providers may utilize the Health Insurance Prospective Payment System (HIPPS) code that was being billed when the beneficiary reached the end of their SNF benefit period.

Home Health Agencies

The waiver provides relief to Home Health Agencies on the timeframes related to OASIS Transmission and Medicare Administrative Contractors (MACs) are allowed to extend the auto-cancellation date of Requests for Anticipated Payment (RAPs).

Bill with Condition Code DR for UB-04 Claims under the allowances noted above. Examples:

- Home Health Agency is unable to complete the OASIS submission timely, due to the COVID-19 staffing impacts, append DR to the patient claims that are negatively impacted.
- Wisconsin Physician Services (WPS) adjusts auto-cancellation of RAP from 60 days to 90 days and admission date cancellation timing from 120 days to 180 days. **Providers should check with their local MAC for adjusted time-frames.**

Critical Access Hospitals

This waives the requirements that Critical Access Hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours.

Bill with Condition Code DR on UB-04 claims when bed limits or length of stay are exceeded. Example:

- Critical Access hospital has reached capacity of 25 beds, may house inpatients in the Emergency Department or other nursing units, as long as they can safely do so.

Acute Psychiatric Providers with Distinct Part Units

The blanket waiver allows:

- Relocation of inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit, where these beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care.
    - Continue to bill for inpatient psychiatric services under the inpatient psychiatric facility prospective payment system for such patients
    - Annotate the medical record to indicate the patient is a psychiatric inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the emergency.
    - Assess the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for.

Bill to the Inpatient Psychiatric Prospective Payment System using Condition Code DR under the allowance above. Examples:

- A behavioral health patient must be moved from a Distinct Part Unit to be treated in an acute care facility on any inpatient acute unit due to capacity management; do not discharge and re-register as an acute care hospital patient.
- Behavioral Health Unit is at maximum capacity and new patient presents in Emergency Department requiring inpatient psychiatric treatment. The individual may be housed on a general medical unit, if safe to do so.

Inpatient Rehabilitation Facility

The blanket waiver allows:

- Relocation of inpatients from the excluded distinct part rehabilitation unit to an acute care bed and unit for IPPS and other acute care hospitals with excluded distinct part inpatient rehabilitation units.
    - The hospital should continue to bill for inpatient rehabilitation services under the inpatient rehabilitation facility (IRF) prospective payment system for such patients
    - Annotate the medical record to indicate the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the emergency.
    - Where the hospital's acute care beds are appropriate for providing care to rehabilitation patients, and such patients continue to receive intensive rehabilitation services.
- Exclusion of patients from the hospital's or unit's inpatient population for purposes of calculating the applicable thresholds associated with the requirements to receive payment as an IRF (commonly referred to as the "60 percent rule")
    - Allowed if an IRF admits a patient solely to respond to the emergency and
    - Annotate the patient's medical record properly identifies the patient as such.
- CMS to apply the exception to facilities not yet classified as IRFs, but that are attempting to obtain classification as an IRF.

Bill using Condition Code DR under the allowance above. Examples:

- Due to capacity management a patient can be treated continually on a unit outside of the excluded IRF unit and still receive required therapies (3-hour rule or 15-hour rule)
    - The 60% rule calculation threshold will exclude patients with DR reported from the acute care unit treatment.
- Patients that are moved into an acute unit from a rehab unit do not have to be discharged and re-registered, rather the IRF stay is billed as a continuous visit when the beneficiary is transferred to the acute care unit not for medical reasons but rather for capacity management reasons.

Durable Medical Equipment Providers

The blanket waiver allows:

- Contractors to waive replacements requirements such that the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required where Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) is lost, destroyed, irreparably damaged, or otherwise rendered unusable or unavailable.
    - Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable or unavailable as a result of the emergency.

Bill modifier -CR on CMS 1500 claims under the allowances noted above.

CMS reminds suppliers that Medicare beneficiaries enrolled in a Medicare Advantage or other Medicare Health Plans should contact their plan directly to find out how it replaces DMEPOS damaged, lost, or unavailable in an emergency.

Long Term Acute Care Hospitals – Not Applicable in Trinity Health

Reference: https://www.cms.gov/files/document/se20011.pdf

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