COVID-19 and Telehealth Coding Toolkit v11

This toolkit was developed to provide guidance to the community-based practices in the Children's Health Network regarding the billing, coding and documentation of telehealth and COVID-19 related services. The Centers for Medicare and Medicaid Services (CMS) announced in a press release on 3/31/20, extensive expansion of coverage of telehealth services affecting "the entire US healthcare system for the duration of the emergency declaration". CMS and our local payers including the Department of Human Services (DHS) have expanded the services that are allowed to be performed via telemedicine including audio/video telemedicine visits and telephone calls for new and established patients while relaxing the requirements for HIPAA compliant platforms. This toolkit will outline our recommendations as your organizations implement telehealth and your clinicians begin seeing patients virtually during this unprecedented pandemic state of emergency.

This toolkit will be updated as needed and distributed. See changes from previous version in red.

Definitions

- Telemedicine Visit: Patient-initiated E/M service via interactive (synchronous) audio and video telecommunication systems
- Telephone Visit: Patient-initiated E/M service via telephonic (audio only) communication – Video not required
- E-Visit: Online digital E/M service (patient-initiated) over a digital platform – Does not require audio or video communication
- E/M: Evaluation and management service (eg, illness-related visit) that includes an evaluation, assessment and a treatment plan

Documentation

- Document in the patient's medical record the E/M provided via any telehealth modality as you would for in-person visits including:
    - Detailed summary of the discussion/counseling provided
    - Relevant items of history (chief complaint, History of Present Illness, Review of Systems, Past/Family/Social History)
    - Relevant items of exam (those exam elements that can be "observed" or noted)
    - Medical Decision Making: Assessment (patient's diagnosis) and Treatment/Plan of Care
- Because many telehealth services will likely be billed based on time (more than ½ the visit spent in counseling/coordination of care), documentation of time is recommended: Document time spent (preferably with start and stop time with AM/PM designations)
- Include the location of the patient and any others present for the E/M service (eg, parent or guardian) as well as the location of the clinician
- Document the specific modality of all visits: **In-person visit,** telemedicine visit, telephone visit or E-visit along with a statement indicating the appropriateness of the modality – Example: "*This telemedicine visit via audio/video was determined to be an appropriate, safe and effective means for service delivery during this pandemic state of emergency*".
- Documentation recommended that verbal consent was obtained to conduct the visit via telehealth – Example: "Patient/Parent consents to visit/treatment performed via telehealth"

Coding and Billing

- **Diagnosis Coding:** Report the most appropriate ICD-10-CM code based on the reason for the visit and any diagnoses that are assessed, treated or affect the care of the patient.
  - The following guidance is taken from the ICD-10-CM Official Guidelines for Coding and Reporting FY 2021 (October 1, 2020-September 30, 2021):
    - New emergent code established by the WHO during an emergency meeting on 1/31/20: **U07.1** *2019-nCoV acute respiratory disease*
      - Effective date for code U07.1 is **4/1/20**
      - Report this code for any confirmed COVID respiratory illness (through positive lab test, presumptive lab test or provider's documentation of COVID-19)
      - Also assign appropriate secondary code for the specific manifestations (eg, **J20.8** *Acute bronchitis due to other specified organisms*, **J12.89** *Other viral pneumonia* or **J80** *Acute respiratory distress syndrome*)
      - For asymptomatic patients who test positive for COVID-19 just use U07.1
    - For symptomatic patients with actual or suspected contact with or exposure to someone who has COVID-19:
      - Assign appropriate symptom code such as **R05** *Cough*, **R06.02** *Shortness of breath* or **R50.9** *Fever, unspecified*
      - Assign **Z20.828** *Contact with and (suspected) exposure to other viral communicable diseases* as a secondary diagnosis
      - If patient is asymptomatic, just use **Z20.828**
    - For symptomatic patients with possible exposure or exposure to COVID-19, but is ruled out after evaluation or testing
      - Assign appropriate symptom code such as **R05**, **R06.02** or **R50.9**
      - Assign **Z03.818** *Encounter for observation for suspected exposure to other biological agents ruled out* as a secondary diagnosis
      - If patient is asymptomatic, just use **Z03.818**
      - During the COVID-19 pandemic, a screening code (eg, **Z11.59** *Encounter for screening for other viral diseases*) would **not** be appropriate
    - For patients presenting for antibody (serology) testing for COVID-19 during the pandemic:
      - Assign **Z01.84** *Encounter for antibody response examination*
      - If the patient had a known or suspected previous exposure to COVID-19, also use **Z20.828** *Contact with and (suspected) exposure to other viral communicable diseases.*
    - For COVID-19 infection in a newborn
      - Assign **U07.1** and the appropriate codes for associated manifestations
      - If COVID-19 was contracted in utero or during the birth process, assign code **P35.8** *Other congenital viral diseases* and **U07.1**
    - For follow-up visits after COVID-19 infection has resolved
      - Assign **Z09** *Encounter for follow-up evaluation after completed treatment for conditions other than malignant neoplasm,* and **Z86.19** *Personal history of other infectious and parasitic diseases* as a secondary code.

- **CPT Coding of Telehealth E/M Services**: performed by a clinician who can report E/M services (eg, MD, DO, NP, PA)
    - **Telemedicine E/M Visit:** Report a new or established patient E/M visit code either based on the key components (history, exam and medical decision-making) documented or based on time.

      NEW PATIENT CLINIC VISITS:
        - 99201 3 of 3 – PF history and exam, SF MDM 10 minutes
        - 99202 3 of 3 – EPF history and exam, SF MDM 20 minutes
        - 99203 3 of 3 – Detailed history and exam, Low MDM 30 minutes
        - 99204 3 of 3 – Comp. history and exam, Moderate MDM 45 minutes
        - 99205 3 of 3 – Comp. history and exam, High MDM 60 minutes

      ESTABLISHED PATIENT CLINIC VISITS:
        - 99212 2 of 3 – PF history and exam, SF MDM 10 minutes
        - 99213 2 of 3 – EPF history and exam, Low MDM 15 minutes
        - 99214 2 of 3 – Detailed history and exam, Moderate MDM 25 minutes
        - 99215 2 of 3 – Comp. history and exam, High MDM 40 minutes

      (Consultations can also be reported via telehealth to those health plans that allow reporting of consultation codes 99241-99245)
        - Use modifier -95 *Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunication system*
        - Use modifier -GT *Via interactive audio and video telecommunication systems*
            - These modifiers are not required by all payers, but can still be appended to all E/M CPT codes done via telemedicine (synchronous audio/video) – Most health plans allow use of the -95 or -GT modifier.
            - Please see Health Plan Grid for specific requirements for each payer
        - Use place of service (POS) 02 *Telehealth – The location where health services and health related services are provided or received, through a telecommunications system*
        - Use POS 11 *Office* (For those payers that require it – See Health Plan Grid)

    - **Telephone Visits:** The CHN recommends reporting one of the following codes based on the amount of time spent in a telephone encounter (without video) performed by a clinician who can report E/M services (eg, MD, DO, NP, PA). While using telephone call codes below continues to be an acceptable way to report audio only telehealth, several commercial payers have indicated that these audio only telehealth services can be reported in the same manner as telemedicine E/Ms. If providers are providing care over the phone that typically had been performed face-to-face, these audio only visits can be reported as if both audio and video were used. (See bullet above for specific billing guidance and see Health Plan Grid for specific requirements for each payer).
        - 99441 5-10 minutes
        - 99442 11-20 minutes
        - 99443 21-30 minutes

- No modifiers are needed on the CPT codes for telephone encounters
- Use place of service (POS) 11 *Office – Location, other than hospital, skilled nursing facility (SNF) military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF) where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.*
- Do not report telephone encounters of less than 5 minutes duration
- Do not report if the telephone encounter is related to a visit within the past 7 days or the if telephone encounter ends with the decision to see the patient in person within 24 hours or the next available urgent appointment time
- Do not report telephone encounter codes for non-evaluative telephonic communication of test results, scheduling of appointments or other communication that does not include evaluation and management of the patient

- **E-Visits / Online Digital E/M:** Report one of the following codes based on the cumulative amount of time spent over a 7 day period performed by a clinician who can report E/M services (eg, MD, DO, NP, PA)
  - 99421 5-10 minutes
  - 99422 11-20 minutes
  - 99423 21 or more minutes
    - No modifiers are needed on the CPT codes for e-visits
    - Use place of service (POS) 11 *Office*
    - Do not report e-visits of less than 5 minutes duration
    - Do not report the e-visit if an in-person E/M visit occurs in the 7 days after the e-visit – that time spent should be incorporated into the E/M visit.
    - Clinic staff time should not be counted toward total time
    - Do not report e-visits for non-evaluative electronic communication of test results, scheduling of appointments or other communication that does not include evaluation and management of the patient

- **CPT and HCPCS Coding for COVID Testing**
  - There are a number of HCPCS and CPT codes to report COVID-19 clinical diagnostic testing. Some codes are distinguished by the type of test (PCR test vs. serology or antibody test), by specific method, or whether the test uses high throughput technology. Please contact JoAnne Wolf at joanne.wolf@childrensmn.org to request a grid outlining the reimbursement for several COVID testing codes and other related procedures.

  - **Coverage for Testing:** There is wide coverage from all payers for clinical laboratory testing for COVID-19 that is ordered by a health care professional during the pandemic public health state of emergency with no cost-sharing (co-pays, co-insurance or deductibles) by the patient. Several health plans have indicated that this same coverage applies to antibody testing. For specific health plan coverage for *serology/ antibody testing, please see Business Administrative Support Section on the CHN website: https://www.childrenshealthnetwork.org/covid19/

Reimbursement

- Prior to the pandemic state of emergency, most health plans reimbursed traditional telemedicine (synchronous audio/video with patient at a host facility) based on the facility fee schedule amount. During the pandemic period, CMS and most health plans have indicated they will be reimbursing clinics the non-facility (clinic) fee schedule amount.
- Mid-level practitioners (eg, NP or PA) will continue to be paid at the same level as before – most at 85% of the fee schedule of physicians
- Relative value units (RVUs) and the resulting reimbursement is significantly less for Telephone encounters (99441-99443) than Telemedicine visits billed with new and established patient E/M codes (99201-99205 and 99212-99215), therefore telemedicine visits (with audio and video) are the preferred modality. See Health Plan Grid as a reference if you prefer to report audio only visits in the same manner as telemedicine E/Ms. NOTE: Not all health plans have confirmed approval of billing audio only in this manner and DHS – Medicaid requires audio only visits to be reported with telephone call codes (99441-99443).

UPDATE 5/12/20: CMS announced a significant increase in the RVUs for 99441-99443. DHS has updated their fee schedule to reflect this increase in RVUs. This fee schedule change is effective for dates of service 3/19/20 and after. DHS will identify claims paid at the lower rate and reprocess them at the new higher rate. Clinics will not need to request adjustments.

Other Guidance:

- The expanded coverage and reimbursement of telehealth and relaxed requirements are temporary and only effective during the pandemic state of emergency.
- The DHS Provider Assurance Statement for Telemedicine form should be submitted (faxed) to DHS prior to billing telehealth services. An updated form (published 4/1/20) can be found on the DHS website at: https://Telephonic Telemedicine Provider Assurance Statement-DHS 6806A
    - If your clinicians had already submitted the previous form, this updated form does not need to be completed and providers are eligible to provide telemedicine services immediately.
    - If your clinicians have not yet submitted, this updated form must be used. DHS has requested that clinics not use POS 02 at this time temporarily (as they finalize system edits) for any new telemedicine providers. In the interim, use POS 11. The CHN will notify clinics once further guidance is published.
    - The DHS COVID-19 revised Telemedicine policy can be found at: DHS Provider Manual: Coronavirus (COVID-19)
    - Also fax the completed Provider Assurance Statement form to UCare at: 612-676-6501 to ATTN: CLAIMS SUPPORT
- For those practices that have just recently implemented telehealth services, we've provided several links that may be helpful as you implement telehealth:
    - American Medical Association (AMA) : AMA Quick Guide to Telemedicine
    - American Academy of Pediatrics (AAP): AAP Telehealth Sample Documents
    - The CHN has developed a standardized telehealth policy template that clinics can revise based on their clinic practice. The template is located in the Business Administrative Support Section on the CHN website: https://www.childrenshealthnetwork.org/covid19/

- Telehealth services may be billed if the clinician is located in their home and providing the service to the patient in their home.
- Telemedicine and telephone encounters may be reported for new patients.
- While HIPAA compliant platforms are strongly recommended, non-HIPAA compliant platforms are permitted to be used for telehealth during the state of emergency
- Most payers have lifted frequency limitations for telemedicine services. For example: DHS has indicated their 3X/week limitation has been waived during the state of emergency
- For telemedicine visits (synchronous audio/video), you can explain to families/patients that they will be billed just like they would if they were being seen in the office (with an office visit code). For telephone only visits, they will be billed specific telephone visit codes that will likely apply the same type of benefits if being seen in the office unless you are billing in the same manner as telemedicine E/Ms for those payers who allow it – See Health Plan Grid.
    - Here is a link to an article that might be helpful to share with parents/patients: A Patient's Guide to Telemedicine: What to Do When Your Doctor Call or Video-Chats with You
- CMS recently announced reimbursement was available for counseling patients to self-isolate at the time of COVID testing (using E/M codes). CMS published a Coronavirus Counseling Checklist that clinics find useful: https://www.cms.gov/files/document/counseling-checklist.pdf.
- On July 15th DHS announced that uninsured Minnesotans can get free COVID-19 tests. Please see the DHS website for details and information on how Minnesotans can apply: https://mn.gov/dhs/media/news/?id=1053-440514

Children's HEALTH NETWORK

Health Plan Grid: Updated

Health Plan	Expanded Telehealth Coverage	Expanded Telehealth Policy Effective date	Audio/Video: POS/Modifier	Telephone Audio only: Codes	Telephone Audio only: POS/Modifier
Aetna and Allina/Aetna Joint Venture	Yes - Policy updated and FAQ online	3/4/2020 through 12/31/2020	POS: 02 Modifier: GT or 95	99441-99443	POS: 02 Modifier: none needed
BCBS of MN - Commercial and PMAP	Yes - Policy updated in late March and FAQ online on 4/12/20	2/4/2020 through 12/31/2020	POS: 02 Modifier: GT or 95	May bill same as Audio/Video	May bill same as Audio/Video
HealthPartners - Commercial and PMAP	Yes - Policy updated in late March and revised 4/9/20	3/17/2020 through the duration of the public health emergency	POS: 02 Modifier: GT or 95	May bill same as Audio/Video	May bill same as Audio/Video
Medica	Yes - Policy updated in early April	3/6/2020 through **1/31/2021**	POS: 02 Modifier: GT or 95	May bill same as Audio/Video	May bill same as Audio/Video
PreferredOne	Yes- Policy updated in late March	2/1/2020 through the duration of the public health emergency	POS: 02 Modifier: 95	May bill same as Audio/Video	May bill same as Audio/Video
UCare	Yes - Policy online updated 4/29/20	3/1/2020 through the duration of the public health emergency	POS: 11 Modifier: 95	99441-99443	POS: 11 Modifier: none needed
United Healthcare	Yes - Policy updated in late March	3/18/2020 through **12/31/2020**	POS: 11 Modifier: 95	May bill same as Audio/Video	May bill same as Audio/Video
Medicaid/DHS	Yes - Updated 4/1/20	3/19/2020 until further notice	POS: 02/11-See Other Guidance Modifier: 95	99441-99443	POS: 11 Modifier: none needed
Medicare/CMS	Yes- Policy updated multiple times	3/1/2020 through the duration of the public health emergency	POS: 11 Modifier: 95	99441-99443	POS: 11 Modifier: none needed

Frequently Asked Questions:

Question: What place of service do I use if the provider sees patient by Telehealth (with video and audio), but then the patient comes in on the same day for just labs? (ie, urine, strep, influenza and hopefully COVID testing). There are talks about doing testing in the parking lot, once the provider sees the patient via telehealth.

Answer: I suggest billing these out as two encounters. One for your E/M for the telemedicine visit (billed with POS 02 or 11 depending on the payer) and then the other for the lab service (with POS 11) - even if the specimen was taken from the parking lot of the clinic.

Question: Can you help us understand if our providers can see a telemedicine patient located in another state? I have reviewed lots of sources and as it stands right now it appears CMS has temporarily removed the border restrictions of licenses and patient locations, but I cannot confirm this 100%. Additionally, one of our providers contacted their PA board and was instructed that we should verify with the state the patient is in (in this case it was Arizona). Any guidance you can provide would be very helpful and appreciated.

Answer: While the HHS 1135 waiver announced by CMS allows for out-of-state clinicians being able to provide telehealth across state lines, unfortunately the states have been slow in allowing it. In researching this issue, I have found multiple articles published by law firms recommending that clinics check with each state in which they plan to provide telehealth services. It appears that some states allow for this, but require you to apply for a temporary license. While others allow you to provide it without notification or application of a temporary license. Here is a link to an article that gives advice on how to manage this operationally:

https://dorseyhealthlaw.com/covid-19-and-cross-state-clinician-licensure-federal-and-state-regulations-revisited-and-what-to-do-about-them/

Here is a link to the Federation of State Medical Boards which shows the different temporary licensing requirements for each state during the COVID-19 state of emergency:

https://www.fsmb.org/advocacy/covid-19/

Question: Are all health plans waiving any patient cost-sharing such as co-insurance?

Answer: The health plans have not been consistent on patient cost-sharing such as the waiving of a patient's co-insurance. Some payers have indicated they will only waive copays for actual COVID-related services such as testing and treatment (eg, office visits or telemedicine visits) with actual COVD diagnoses. And their expanded temporary policies all have varying effective dates of coverage.

- UPDATE: Please see the grid for specific payer policies on cost sharing during the pandemic on the CHN website under Business Administrative Support Section on the CHN website: https://www.childrenshealthnetwork.org/covid19/

Question: Can well child checks be performed and billed as telemedicine?

Answer: Currently the preventive visit codes (eg, 99393) are not listed in the CPT manual as those codes that may be used for synchronous telemedicine services. However, the MN AAP and a consortium of other pediatric medical organizations have contacted DHS and requested the ability to bill for preventive visits via telemedicine. We will provide updates as they become available.

DHS recently posted guidance on C&TC services via telemedicine: DHS MHCP Provider News - C&TC Visit Reminders During COVID-19 Pandemic However the MN AAP consortium is still in discussions with DHS regarding the reporting of complete C&TCs. We will provide updates as they become available.
UPDATE: BCBS of MN, HealthPartners, Medica and United Healthcare all indicate some coverage for preventive medicine visits performed via telemedicine.

Question: Can the PHQ-9 (96127) be billed as telemedicine? Our clinicians are having the patient complete this form or they are going over the form verbally and completing the depression screening during the telemedicine visit for depression and/or anxiety.

Answer: Currently code 96127 is not listed in the CPT manual as a code that may be used for synchronous telemedicine services. However, most health plans list this code as acceptable to be performed via telemedicine. We recommend reporting the service to the health plans in the same manner you are doing for the associated telemedicine visit (with POS 02 and modifier 95 or GT). See question below on documentation of standardized tools performed via telemedicine.

Question: How should the completion of standardized tools performed via telemedicine be documented?

Answer: Documentation should show how the form was completed (eg, verbally through clinician, form completed and sent to clinician or form completed online). Examples include: PHQ-9, GAD-7, and Asthma Control Test (ACT). The score and interpretation should be documented in the medical record along with any anticipatory guidance, counseling or management provided based on the results.

Question: How would I bill this scenario – Provider has a telemedicine visit scheduled and is performing the visit and the video goes out on the patient end so the last 5 minutes is on the phone. Can I just bill the telemedicine visit as that is what the majority of the visit was?

Answer: Since the majority of the visit was performed as a telemedicine visit and since most health plans are now allowing billing telephone in the same manner as telemedicine, I would recommend billing as telemedicine visit - with an E/M code, POS 02 or 11 depending on the payer and modifier 95 or GT.

Question: Can a patient be seen for 2 telemedicine visits (synchronous audio/video) in a row within 7 days?

Answer: Yes, since you are reporting the telemedicine (audio and video) visit with a regular E/M code. The 7 day rule applies to the telephone visit codes (99441-99443) and the online digital E/M visits (99421-99423).

Question: Which providers can report the Telephone Call E/M codes (99441-99443) and the Online Digital E/M codes (99421-99423)?

Answer: The codes in the E/M chapter of the CPT manual (994421-99423 and 99441-99443) can be used by those providers who are eligible to bill E/M services (MD, DO, NP, PA, etc.). The codes in the Medicine section of the manual (98966-98968) and (98970-98972) are reserved for those providers unable to bill E/M services (Speech Language Pathologists, OT, PT, Social Workers, Dietitians, etc.). Per CMS, registered nurses (RNs) are not able to report the codes listed in the Medicine section of the manual (98966-98968 and 98970-98972).

Question: Will we be limited in the level of E/M billed due to the service being performed via telehealth?

Answer: If you are billing a telemedicine visit (synchronous audio/video), you can bill that service based on time (if more than 1/2 the visit spent in counseling) or on the 3 key components: history, exam, medical decision making (MDM). For a 99214, it requires 25 minutes for time - or - 2 of 3 key components met (eg, detailed history, detailed exam and moderate MDM). So even if the exam is limited due to the telemedicine modality, you could potentially still report a 99214 if the history and MDM met that level.

Question: If a Prior Authorization was obtained for a surgery that has been postponed due to the COVID-19 pandemic, will there be an extension on the prior authorization?

Answer: Most health plans have extended the timeframe of the prior authorization. For a listing of the specific policy for each health plan see the CHN website (under Business Administrative Support): https://www.childrenshealthnetwork.org/covid19/

Question: CMS developed two codes for specimen collection for COVID-19 testing – **G2023** *Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source* and **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*. Can these codes be billed by clinics for obtaining the specimens and sending to the outside labs for testing?

Answer: No, it appears that these two codes developed by CMS are only billable by clinical diagnostic laboratories for when they need to send trained personnel to obtain specimens for testing: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf. Clinics may report CPT code **99000** *Handling and/or conveyance of specimen for transfer from the office to a laboratory*. However, many health plans deny this code as bundled into an E/M code. If the patient is coming in just for a brief assessment and specimen collection and not seen by the clinician (and no telemedicine visit was reported on the same calendar day), code 99211 may be reported.
UPDATE: Several health plans have listed code G2023 as billable by clinics. Test claims indicate that most health plans are reimbursing separately for G2023 for COVID-19 specimen collection when billed alone or with an E/M service (in-person or via telehealth). Reminder: If a patient is seen via telehealth and then comes into the clinic for a COVID-10 specimen collection, continue to separate these two claims. You will need to bill with the appropriate modifier and place of service (POS) for the telehealth E/M separately from the specimen collection, which will be reported with POS 11 for clinic.

Question: Is there a way to bill out **94664** *Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device* along with the televisit? Some of our providers are going over the nebulizer via the video visit, but unfortunately these are being denied by insurance.

Answer: This code may appear on the CMS list of eligible telehealth codes, however it does not appear on the list for the other health plans. So this code does not appear to be eligible for reimbursement if done via telemedicine at this time. UPDATE: Several health plans will now allow 94664 to be reported as performed via telehealth (BCBS of MN, Medica, PreferredOne, United Healthcare, and UCare).

Question: Will the health plans be extending their temporary telehealth policies?

Answer: Several health plans have already extended their temporary policies in relation to cost sharing and prior authorizations. Most indicate their temporary telehealth policies with continue through the duration of the public health emergency. With the extension of the national state of emergency announced by HHS Secretary Alex Azar, III, most payers have extended their temporary policies relating to telehealth, cost-sharing and prior authorizations to at least the end of the 2020. Please see updated Health Plan Grid on page 7.

Question: We are receiving denials from UCare when billing telemedicine visits using an E/M code with POS 11 (per their policy) as inappropriate POS. We are also having our telephone call codes 99441-99443 being denied as not covered.

Answer: UCare indicates that this is a system issue for all telehealth claims. They are still working on the issue to be able to auto adjudicate claims but the systems have been updated to a least receive claims and pend them instead of denying them. We have not been given an estimated time of when their system will be updated. UPDATE: UCare updated their claims system 5/20/2020 so POS 11 will no longer result in a denial. For earlier claims that were denied, UCare will be reprocessing these denied claims starting the week of 6/15. Clinics will not need to do anything. However, for any claims submitted with a POS 02 and paid at the lower facility rate, clinics need to resubmit those with the correct POS (eg, 11), to receive the applicable payment. For telephone claims (billed with 99441-99443), UCare is still in the process of configuring their system. On 5/20, they started pending claims, prior to that, they were denying telephone claims as non-covered. UCare is expecting the claims configuration to be complete by next week. They will then begin reprocessing the denied claims and processing the pended claims. Again, clinics will not need to do anything.

Question: We've noticed that the fee schedule amount for a telemedicine visit (eg, 99213) is not the same as when we bill an in-person visit. Is this because of the modifier -95?

Answer: A reduction in the fee schedule amount may have more to do with the place of service (POS) code that is used for the claim. Prior to the public health emergency (PHE), telemedicine services were instructed by all health plans to be billed with POS 02 and were paid at the facility rate (which is lower than the non-facility rate). However with the PHE, most (if not all) payers have indicated they intend to reimburse at the level that would have been paid face-to-face (F2F). In order to do so, several health plans (eg, United Healthcare) have instructed clinics to report POS 11 if the service would have been performed in the clinic F2F rather than POS 02. If billed with POS 02 for some of these health plans, services may be paid at the lower facility fee schedule rate. Clinics may submit corrected claims to these health plans to have their claims reprocessed and paid at the higher non-facility rate. Please see the Health Plan Grid on page 6 of this toolkit for specific guidance on modifier and POS use for each payer.

Question: Will the temporary expanded telemedicine coverage continue after the pandemic state of emergency is lifted?

Answer: President Trump issued an executive order on 8/3/20 directing the Health and Human Services (HHS) Secretary to issue rules within 60 days making some of the changes made during the COVID-19 pandemic permanent allowing for continued access to telehealth for Medicare patients once the public health emergency ends. Although this order applies to the Medicare program, other payers will likely follow suit.

Question: CPT announced a new code **99072** *Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency as defined by law, due to respiratory-transmitted infectious disease*. Will this new code be reimbursed by the payers?

Answer: Several payers have indicated in their COVID policies that this code will not be paid separately and will deny as bundled. However, DHS indicates they will reimburse separately for this code. This would apply only to those patients who are covered on straight Medicaid (which is a small percentage of your patients on state public programs). DHS will allow 20% (CPI) of the billed amount. We will be addressing this code with the health plans and will provide any updates.

Question: When will the payers' COVID cost sharing policies expire?

Answer: Several payers have extended this through the end of the Public Health Emergency (PHE). All others have extended their temporary policies waiving any cost sharing (co-pay, deductible) for COVID related services through the end of 2020. For specific information for each payer, please see the Business Administrative Support Section on the CHN website: https://www.childrenshealthnetwork.org/covid19/

Question: UHC has been denying or applying a copay for the E/M that is billed with COVID testing. They indicated that a specific ICD-10 code must be used on the claim in order for the cost sharing to be waived. Which ICD-10 code should be used?

Answer: I recommend that providers use code Z20.828 (as an additional code to symptoms such as cough, fever, etc) to show that there was either actual or suspected exposure to COVID. This is consistent with ICD-10 guidelines. See the highlighted section in the Diagnosis Coding section on page 2. Some health plans have also recommended using modifier CS for claims that are COVID related (testing, any E/M to determine need for testing, treatment).

Question: Scenario: The patient shows up to our clinic for COVID testing that is performed in the parking lot. The provider performs an E/M over the phone from inside the clinic to the patient/parent in the car in the parking lot. Should the visit be reported as telemedicine or a telephone call?

Answer: Per the CMS FAQ: 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.

For Other Questions Contact:
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