COVID-19, Coding, Billing & Telehealth Tip Sheet - April 1, 2020

New ICD-10-CM code for the 2019 Novel Coronavirus (COVID-19)
Effective: DOS April 1, 2020 and after

COVID-19 Infections	ICD-10-CM Diagnosis Codes
Pneumonia due to COVID-19	U07.1, J12.89
Acute Bronchitis due to COVID-19	U07.1, J20.8
Bronchitis (NOS) due to COVID-19	U07.1, J40
COVID-19 associated w/lower or acute respiratory infection (NOS)	U07.1, J22
COVID-19 associated w/respiratory infection (NOS)	U07.1, J98.8
*Acute Respiratory Distress syndrome (ARDS) due to COVID-19	U07.1, J80
Asymptomatic, test result positive for COVID-19	U07.1

Provider's documentation that individual has COVID-19 is sufficient – type of test performed is not required for "confirmation" of diagnosis

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ICD-10-CM Official Coding Guidelines – Supplement
Coding encounters related to COVID-19 Coronavirus Outbreak
Effective: February 20, 2020

Condition Related to COVID-19 DOS UP TO & INCLUDING 03/31/2020	ICD-10 Code
Pneumonia due to COVID-19	J12.9, B97.29
Acute Bronchitis due to COVID-19	J20.8, B97.29
Bronchitis (NOS) due to COVID-19	J40, B97.29
COVID-19 associated w/lower or acute respiratory infection (NOS)	J22, B97.29
COVID-19 associated w/respiratory infection (NOS)	J98.8, B97.29
*Acute Respiratory Distress Syndrome (ARDS) due to COVID-19	J80, B97.29

*ARDS – Interim clinical guidance w/confirmed COVID-19
https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html

Exposure Codes – not impacted by DOS

Possible exposure to COVID-19**, ruled out after evaluation**
- **Z03.818**

Exposure to person confirmed w/COVID-19
- **Z20.828**

Screening for COVID-19
Asymptomatic, no known exposure (negative/unknown results)
- **Z11.59**

Revised: 04/03/2020

Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS)Codes

Coding encounters related to COVID-19 Testing **Effective: April 1, 2020**
Retroactive claims accepted from February 4th forward

Laboratory Services	
Code	**Description**
U0001	CDC testing laboratories to test patients for SARS-CoV-2
U0002	non-CDC laboratory tests for SARS-CoV2/2019-nCoV (COVID-19)

Additional Information:
Do not report, if your office is not running the test for SARS-CoV-2, COVID-19

New CPT related to COVID-19 Laboratory Testing
Effective: Dates of service after March 12, 2020

The AMA created ***CPT 87635*** – 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

- Use to efficiently report/track testing services related to SARS-CoV-2
- Streamline reporting and reimbursement for testing in the US
- Contact your local third-party payer to determine their specific guidelines
- If multiple separate specimens are taken for same virus/same patient/same day (Naso- and oropharyngeal swabs), report 87635, 87635/59

With the rapidly changing situation surrounding the COVID-19 emergency, accurate coding of COVID-19 encounters can be confusing and complicated. We will continue to monitor key resources (WHO, CDC, CMS, AMA) and update our coding tip sheets to provide the most up to date guidance.

For more information please contact Bill Hannah: bill.hannah@guidehouse.com

COVID-19, Coding, Billing & Telehealth Tip Sheet

Billing

Billing Professional Services & Facility Charges

Billing Profession Services

The OIG is providing flexibility for providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

CMS is not requiring *additional* or *different* modifiers associated with telehealth services furnished under these waivers.

However, consistent with current rules, the three scenarios requiring modifiers on Medicare telehealth claims:

1. Append GQ – telehealth via asynchronous (store & forward) technology as part of federal telemedicine demonstration project in Alaska and Hawaii
2. Append GT – telehealth service rendered via synchronous telecommunications billed under CAH Method II
3. Append G0 – when telehealth service is furnished for purposes of diagnosis and treatment of an acute stroke

Medicare telehealth services: Use Place of Service (POS) code 02 – telehealth

Due to the current Public Health Emergency (PHE) declaration, providers will be required to report the following for non-telehealth services:
Modifier "CR" (catastrophe/disaster related) modifier for Part B billing, both institutional and non-institutional

Billing Facility Services

Due to the current Public Health Emergency (PHE) declaration, facilities will be required to report the following:

- Condition code "DR" (disaster related) for claims submitted using the ASC X12 837 institutional claims format of paper Form CMS-1450.

For additional information:

- https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Resources/Waivers-and-flexibilities.html
- https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf
- https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf

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Telehealth Services

Expanded Telehealth Services: COVID-19
Effective: March 6, 2020

Three main types of virtual services provided to Medicare beneficiaries:

Telehealth

- 99201 – 99215 – Office or other outpatient visits
- G0425 – G0427 – Telehealth consults, ED or initial inpatient
- G0406 – G0408 – Follow-up inpatient telehealth consults furnished to beneficiaries in hospitals or SNFs
- For complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Key Takeaways

- Considered same as in-person visits, paid at same rate
- Professional services furnished to beneficiaries in all areas of the country in all settings will be paid
- Medicare coinsurance and deductible still apply
- OIG is providing flexibility for healthcare providers to reduce or waive cost-sharing for services paid by federal healthcare programs
- HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public-health emergency

Virtual Check Ins

- G2012 - Brief technology-based service provided to ***established patient***, not originating from related E&M within the previous 7 days, nor leading to E&M or procedure within the next 24 hrs (or soonest available appt.), 5-10 minutes medical discussion.
- G2010 - Remote evaluation of recorded video and/or images ***submitted by established patient***, includes interpretation and follow up with patient within 24 business hours, not originating from related E&M within 7 days nor leading to E&M service or procedure within the next 24 hours (or soonest available appt.).

Key Takeaways

- Only report when the billing practice has an established relationship with the patient
- No longer limited to rural setting only (expanded settings)
- Individual services need to be agreed to by patient
- Can be conducted with a broader range of communication methods (telephone, audit/video, secure texts, email or portal) Standard Part B cost sharing applies

E-Visits

Online digital E&M service, for ***established patient***, for up to 7 days, cumulative time during the 7 days

- 99421 – 5-10 Minutes
- 99422 – 11-20 Minutes
- 99423 – 21 or more Minutes

Qualified nonphysician healthcare professional online assessment, for an ***established patient***, for up to seven days, cumulative time during the 7 days

- G2061 – 5-10 Minutes
- G2062 – 11-20 Minutes
- G2063 – 21 or more Minutes

Key Takeaways

- Only reported when the billing practice has an established relationship with the patient
- No geographical or location restrictions for E-visits
- Communication via online patient portals
- Individual services must be initiated by the patient
- Medicare coinsurance and deductible generally apply to these services