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CPAs & BUSINESS ADVISORS

COVID-19 CODING AND BILLING – PART 1

December 17, 2020 | Montana Rural Health Flexibility Program

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ICD-10 UPDATES 01/01/2021

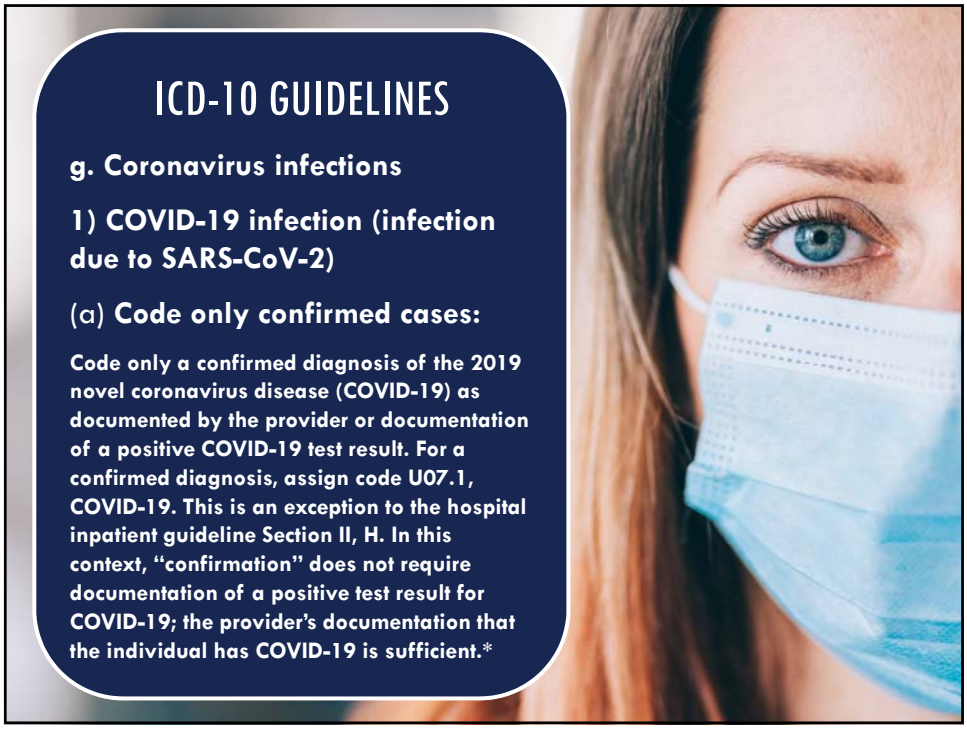
From the CDC: *"Given this development there is an ongoing and urgent need to capture more information about this condition in our surveillance data and the nation's health care claims. The Centers for Disease Control (CDC), under the National Emergencies Act Section 201 and 301, is announcing further additions to ICD-10-CM Classification related to COVID-19, that will become effective January 1, 2021.*

As a result of the ongoing COVID-19 public health emergency, the Centers for Disease Control and Prevention's National Center for Health Statistics (CDC/NCHS) is implementing additional codes into the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for reporting to include:

ICD-10 UPDATES 01/01/2021

- Encounter for screening for COVID-19 (Z11.52)
- Contact with and (suspected) exposure to COVID-19 (Z20.822)
- Personal history of COVID-19 (Z86.16)
- Multisystem inflammatory syndrome (MIS) (M35.81)
- Other specified systemic involvement of connective tissue (M35.89)
- Pneumonia due to coronavirus disease 2019 (J12.82)

*Watch for updated ICD-10-CM Guidelines



*SE20015 REVISED 08/17/20

To address potential Medicare program integrity risks, effective with **admissions occurring on or after September 1, 2020**, claims eligible for the 20 percent increase in the *MS-DRG weighting factor will also **be required to have a positive COVID-19 laboratory test** documented in the patient's medical record. Positive tests must be demonstrated using only the results of viral testing (i.e., molecular or antigen), consistent with CDC guidelines. The test may be performed either during the hospital admission or prior to the hospital admission.

For this purpose, a viral test performed within 14 days of the hospital admission, including a test performed by an entity other than the hospital, can be manually entered into the patient's medical record to satisfy this documentation requirement. For example, a copy of a positive COVID-19 test result that was obtained a week before the admission from a local government-run testing center can be added to the patient's medical record. In the rare circumstance where a viral test was performed more than 14 days prior to the hospital admission, CMS will consider whether there are complex medical factors in addition to that test result for purposes of this documentation requirement.

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ICD-10 GUIDELINES

If provider documents "suspected "possible" "probable," or "inconclusive" COVID-19, do not assign code U07.1. Instead, code the signs and symptoms reported. See guideline I.C.1.g.1.g.

(b) **Sequencing of codes**

When COVID-19 meets the definition of principal diagnosis, code U07.1, COVID-19, should be sequenced first, followed by the appropriate codes for associated manifestations, except when another guideline requires that certain codes be sequenced first, such as obstetrics, sepsis, or transplant complications.

For a COVID-19 infection that progresses to sepsis, see Section I.C.1.d. Sepsis, Severe Sepsis, and Septic Shock

See Section I.C.15.s. for COVID-19 infection in pregnancy, childbirth, and the puerperium

See Section I.C.16.h. for COVID-19 infection in newborn

For a COVID-19 infection in a lung transplant patient, see Section I.C.19.g.3.a. Transplant complications other than kidney.

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ICD-10 GUIDELINES

(c) **Acute respiratory manifestations of COVID-19:**

When the reason for the encounter/admission is a respiratory manifestation of COVID-19, assign code U07.1, COVID-19, as the principal/first-listed diagnosis and assign code(s) for the respiratory manifestation(s) as additional diagnoses.

The following conditions are examples of common respiratory manifestations of COVID-19.

(i) Pneumonia:

For a patient with pneumonia confirmed as due to COVID-19, assign codes U07.1, COVID-19, and J12.89*, Other viral pneumonia. *(will change to J12.82 as of 01/01/21)

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ICD-10 GUIDELINES

(ii) 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.

(iii) 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.

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ICD-10 GUIDELINES

(iv) Acute respiratory distress syndrome:

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

(v) Acute respiratory failure:

For acute respiratory failure due to COVID-19, assign code U07.1, and code J96.0-, Acute respiratory failure.

(d) Non-respiratory manifestations of COVID-19:

When the reason for the encounter/admission is a non-respiratory manifestation (e.g., viral enteritis) of COVID-19, assign code U07.1, COVID-19, as the principal/first-listed diagnosis and assign code(s) for the manifestation(s) as additional diagnoses.

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ICD-10 GUIDELINES

(e) Exposure to COVID-19:

For asymptomatic individuals with actual or suspected exposure to COVID-19, assign code Z20.828, Contact with and (suspected) exposure to other viral communicable diseases.

For symptomatic individuals with actual or suspected exposure to COVID-19 and the infection has been ruled out, or test results are inconclusive or unknown, assign code Z20.828, Contact with and (suspected) exposure to other viral communicable diseases. See guideline I.C.21.c.1, Contact/Exposure, for additional guidance regarding the use of category Z20 codes.

If COVID-19 is confirmed, see guideline I.C.1.g.1.a.

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ICD-10 GUIDELINES

(f) *Screening for COVID-19:

During the COVID-19 pandemic, a screening code is generally not appropriate. For encounters for COVID-19 testing, including preoperative testing, code as exposure to COVID-19 (guideline I.C.1.g.1.e).

Coding guidance will be updated as new information concerning any changes in the pandemic status becomes available.

***01/01/21 – Z11.52 – Encounter for screening for COVID-19**

- **For an encounter for COVID-19 testing being performed as part of preoperative testing, assign code Z01.812, Encounter for preprocedural laboratory examination, as the first-listed diagnosis and assign code Z20.828 [to be replaced with Z20.822 as of 1/1/2021] as an additional diagnosis.**

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ICD-10 GUIDELINES

(g) Signs and symptoms without definitive diagnosis of COVID-19:

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 COVID-19, assign *Z20.828, Contact with and (suspected) exposure to other viral communicable diseases, as an additional code.

*** Z20.822 01/01/21**

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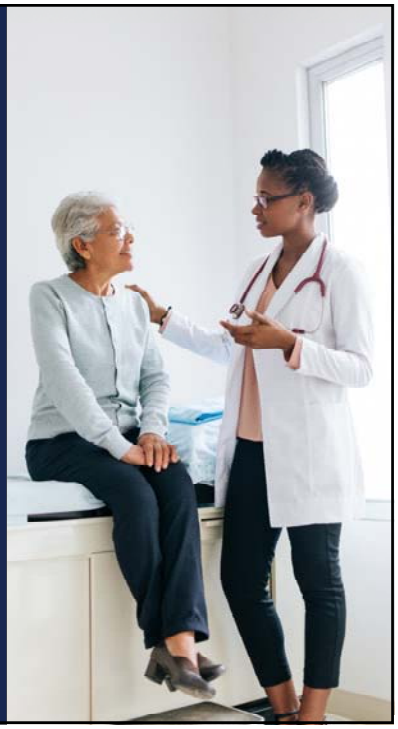
ICD-10 GUIDELINES

(h) Asymptomatic individuals who test positive for COVID-19:

For asymptomatic individuals who test positive for COVID-19, see guideline I.C.1.g.1.a. Although the individual is asymptomatic, the individual has tested positive and is considered to have the COVID-19 infection.

(i) Personal history of COVID-19:

For patients with a history of COVID-19, assign code *Z86.19, Personal history of other infectious and parasitic diseases. *Z86.16 01/01/21



ICD-10 GUIDELINES

(j) Follow-up visits after COVID-19 infection has resolved:

For individuals who previously had COVID-19 and are being seen for follow-up evaluation, and COVID-19 test results are negative, assign codes Z09, Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm, and *Z86.19, Personal history of other infectious and parasitic diseases.

***Z86.16 01/01/21**

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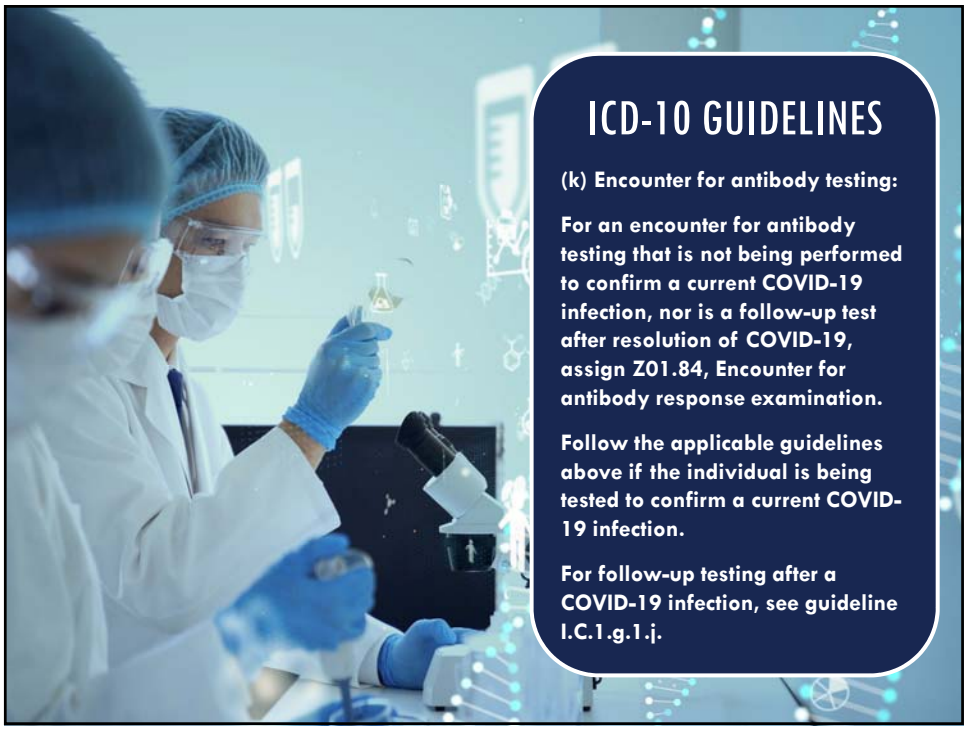

ICD-10 UPDATE

- *Question: What is the ICD-10-CM diagnosis code(s) for a child admitted due to documented multisystem inflammatory syndrome in children (MIS-C) due to COVID-19? (7/23/2020)*
- Answer: Assign code **U07.1**, COVID-19, as the principal diagnosis, and code **M35.8**, Other specified systemic involvement of connective tissue [to be replaced with M35.81 as of 1/1/2021], as a secondary diagnosis, for MIS-C due to COVID-19.
- The MIS-C is a manifestation of the COVID-19 infection. Per the instructional note under code U07.1, COVID-19 should be sequenced as the principal diagnosis and additional codes should be assigned for the manifestations.

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ICD-10 UPDATES

AHA/AHIMA FAQ#37: Past COVID-19 and MIS-C:

- *Question: A child diagnosed with COVID-19 several weeks ago is now admitted with multisystem inflammatory syndrome in children (MIS-C) due to COVID-19. **The patient no longer has COVID-19**. How should this be coded? (7/23/2020)*
- Answer: Assign code **M35.8**, Other specified systemic involvement of connective tissue, as the principal diagnosis [to be replaced with M35.81 as of 1/1/2021], for the MIS-C, and code **B94.8**, Sequelae of other specified infectious and parasitic diseases, as a secondary diagnosis for the sequelae of a COVID-19 infection.
- If the documentation is not clear regarding whether the physician considers a condition to be an acute manifestation of a current COVID-19 infection vs. a residual effect from a previous COVID-19 infection, query the provider. As stated in the Official Guidelines for Coding and Reporting, the provider's documentation that the individual has COVID-19 is sufficient for coding purposes.

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ICD-10-PCS

- XW033E5, Introduction of Remdesivir Anti-infective into **Peripheral** Vein, Percutaneous Approach, New Technology Group *5*
- XW043E5, Introduction of Remdesivir Anti-infective into **Central** Vein, Percutaneous Approach, New Technology Group *5*
- XW033G5, Introduction of Sarilumab (**Kevzara**) into **Peripheral** Vein, Percutaneous Approach, New Technology Group *5*
- XW043G5, Introduction of Sarilumab into **Central** Vein, Percutaneous Approach, New Technology Group *5*
- XW033H5, Introduction of Tocilizumab (**Actemra**) into **Peripheral** Vein, Percutaneous Approach, New Technology Group *5*
- XW043H5, Introduction of Tocilizumab into **Central** Vein, Percutaneous Approach, New Technology Group *5*

- These codes should only be assigned when these drugs are administered to treat COVID-19.

ICD-10-PCS

- XW13325 –Transfusion of Convalescent Plasma (Nonautologous) into **Peripheral** vein, percutaneous approach, New Technology Group *5*
- XW14325 - Transfusion of Convalescent Plasma (Nonautologous) into **Central** vein, percutaneous approach, New Technology Group *5*

- When a more specific ICD-10-PCS code exists, such as stem cell transfusion, assign that code rather than one of the less specific new technology codes. (FAQ#6)

MEDICARE MONOCLONAL ANTIBODY

Bamlanivimab – investigational monoclonal antibody therapy:

- Approved for the treatment of mild to moderate COVID-19 in adults and pediatric patients with positive COVID-19 test results who are at high risk for progressing to severe COVID-19 and hospitalization.
- May only be administered in settings in which health care providers have immediate access to medication to treat a severe infusion reaction and the ability to activate the emergency medical system.
- Report the infusion with **M0239** (includes the infusion and post administration monitoring).
- Q0239 has been assigned for injection Bamlanivimab 700 mg. However, it is being supplied by the government at no cost and should not be reported on the claim at this time.

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MEDICARE MONOCLONAL ANTIBODY THERAPY

- Per the Instruction sheet: Health care providers who participate in a Medicare Advantage Plan should submit claims for Bamlanivimab administration to Original Medicare for all patients enrolled in Medicare Advantage in 2020 and 2021.
- People with Medicare pay no cost sharing for these monoclonal antibody infusion:
  - No copayment/coinsurance
  - No deductible
- Fact Sheet (http://pi.lilly.com/eua/bamlanivimab-eua-factsheet-hcp.pdf) for Health Care Providers EUA of Bamlanivimab regarding the limitations of authorized use. Documentation and consent requirements are extensive.

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MEDICARE MONOCLONAL ANTIBODY THERAPY

Casirivimab and imdevimab -investigational monoclonal antibodies

- Approved for the treatment of mild to moderate COVID-19 in adults and pediatric patients with positive COVID-19 test results who are at high risk for progressing to severe COVID-19 and hospitalization.
- May only be administered in settings in which health care providers have immediate access to medication to treat a severe infusion reaction and the ability to activate the emergency medical system.
- Report the infusion with **M0243** (includes the infusion and post administration monitoring).
- Q0243 has been assigned for injection casirivimab and imdevimab 2400 mg. However, it is being supplied by the government at no cost and should not be reported on the claim at this time.

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MEDICARE MONOCLONAL ANTIBODY

- Effective November 21, 2020
- Instruction sheet to come
- https://www.regeneron.com/sites/default/files/treatment-covid19-eua-fact-sheet-for-hcp.pdf
- https://www.regeneron.com/casirivimab-imdevimab

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REMDESIVIR – MEDICARE INPATIENT ONLY

As you note in your inquiry, at this time Medicare coverage of Remdesivir is for inpatient hospital use. CMS implemented new procedure codes to allow Medicare and other insurers to identify the use of the therapeutics such as Remdesivir a for treating hospital *in-patients* with COVID-19. These new codes went into effect August 1st and are implemented into the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS). ICD-10-PCS is the Health Insurance Portability and Accountability Act (HIPAA) designated code set for reporting hospital inpatient procedures, which is developed and maintained by CMS and can be used by other health insurers. For additional information on the codes, see ICD-10 MS-DRGs Version 37.2 Effective August 1 (PDF).

As also referenced in your inquiry, and indicated in IFC-4, to date, no drug or biological product has an emergency use authorization (EUA) for the treatment of patients with COVID–19 in the outpatient setting. I do understand your note regarding the interpretation of "acute care available" in reference to the FDA FAQs regarding Remdesivir to treat COVID-19. This could be a reference to use of these drugs to treat inpatient hospitalized patients at, for example, temporary hospital relocations under CMS "Hospitals Without Walls" waiver and flexibilities during the PHE. However, Remdesivir is not currently authorized for use in the outpatient setting.

As you know, the current PHE has presented us all with a very dynamic situation. CMS asks providers to please continue to keep abreast of changes and updates by browsing our most up-to-date publications, including FAQs on COVID-19 Medicare Fee For Service billing, provider toolkits, and the most recent Medicare policy and regulatory revisions in response to the COVID-19 public health emergency, via the following CMS websites:
www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page
www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive

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VACCINES - AMA

Appendix Q: Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) Vaccines

This table links the individual severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine product codes (91300, 91301) to their associated immunization administration codes (0001A, 0002A, 0011A, 0012A), manufacturer name, vaccine name(s), 10 and 11-digit National Drug Code (NDC) Labeler Product ID, and interval between doses. These codes are also located in the Medicine section of the CPT code set.

Additional introductory and instructional information for codes 0001A, 0002A, 0011A, 0012A and 91300, 91301 can be found in the Immunization Administration for Vaccines/Toxoids and Vaccines, Toxoids guidelines in the Medicine section of the CPT code set.

Vaccine Code	Vaccine Code Descriptor	Vaccine Administration Code(s)	Vaccine Manufacturer	Vaccine Name(s)	NDC 10/NDC 11 Labeler Product ID (Vial)	Dosing Interval
91300	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted, for intramuscular use	0001A (1st dose) 0002A (2nd dose)	Pfizer, Inc	Pfizer-BioNTech COVID-19 Vaccine	59267-1000-1 59267-1000-01	21 days
91301	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage, for intramuscular use	0011A (1st dose) 0012A (2nd dose)	Moderna, Inc	Moderna COVID-19 Vaccine	80777-273-10 80777-0273-10	

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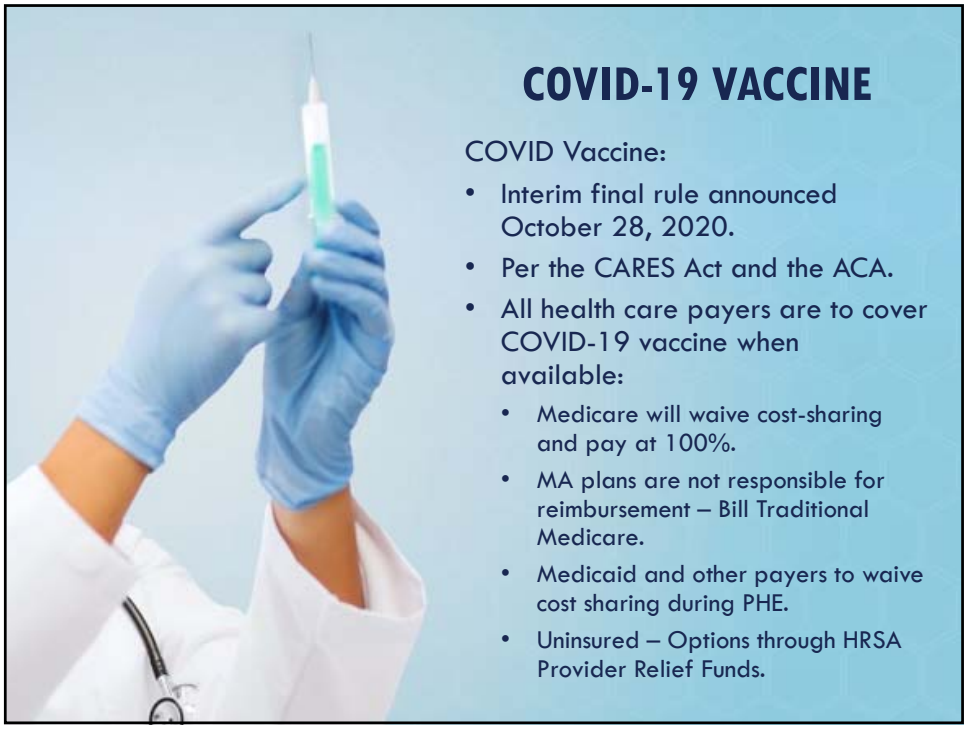

COVID-19 VACCINE

COVID Vaccine:

- Interim final rule announced October 28, 2020.
- Per the CARES Act and the ACA.
- All health care payers are to cover COVID-19 vaccine when available:
  - Medicare will waive cost-sharing and pay at 100%.
  - MA plans are not responsible for reimbursement – Bill Traditional Medicare.
  - Medicaid and other payers to waive cost sharing during PHE.
  - Uninsured – Options through HRSA Provider Relief Funds.

COVID-19 VACCINE REIMBURSEMENT

National average of administration charges:

- $28.39 = Single-dose vaccine
- $16.94 = Initial dose when multiple doses are to be given
- $28.39 = Final dose in series

Rates adjusted per geographic location while recognizing additional costs:

- Resources for public health reporting
- Conducting outreach
- Patient education
- Answering patient questions about the vaccine

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COVID-19 LAB CODES

COVID-19 is caused by SARS-CoV-2

- Three types of tests related to SARS-CoV-2:
  - For acute infection:
    - Nucleic acid (PCR) testing
    - Antigen testing
  - For surveillance and evaluation of previous exposure:
    - Antibody testing

Codes that describe the testing for SARS-CoV-2 (aka COVID-19)

- Acute Infection:
  - Nucleic Acid (PCR) testing; CPT 87635
  - CMS HCPCS codes: U0001, U0002, U0003 and U0004
  - Multiplex codes include 87471 (already established) and 2 new child codes; 87636 and 87637.
    - 87636 – when SARS-CoV-2 and influenza A&B are tested
    - 87637 – when SARS-CoV-2, influenza A&B and RSV are tested

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COVID-19 LAB CODES

- Antigen Testing – less expensive and quicker result:
  - Clarifying language was added to CPT to help determine which code sets to report
  - Microscopic by direct/indirect immunofluorescent assay technique- report 87260-87300
  - For non-microscopic immunochemical technique – report 87301-87451 and 87802-87899
  - Detection by immunoassay with direct optical (visual) observation – report 87802-87899
  - 87802-87899 - some tests that are visually read need to be reported using 87301-87451because of the type of test it is.
  - 87301-87451 describe an enzyme immunoassay (EIA), enzyme-linked immunosorbent assay (ELISA) or a fluorescence immunoassay (FIA) *(See CPT Assistant November 2020)*
- Surveillance and evaluation of previous exposure:
  - Antibody Testing
  - Immunoassay for infectious agent antibodies, quantitative and semiquantitative; 86318 (already established)
  - and 86328, new child code specific for SARS-CoV-2
  - New code 86769 – Antibody; SARS-Cov-2
  - Additional new codes – 86408 and child code 86409 and 86413

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COVID-19 LAB CODES

Surveillance and evaluation of previous exposure

- Antibody Testing
- Immunoassay for infectious agent antibodies, quantitative and semiquantitative; 86318 (already established) and 86328, new child code specific for SARS-CoV-2
- New code 86769 – Antibody; SARS-Cov-2
- Additional new codes – 86408 and child code 86409 and 86413

PLA Codes

- These are the most specific and are particular to the manufacturer. Use these instead of a Category I or III code if they accurately describe the test being performed.
- 0202U (BioFire), 0223U (QIAstat-Dx), 0224U (Mt. Sinai) 0225U (ePlex), 0226U (Ethos Labs), 0240U
- (Cepheid Xpert Xpress-COVID & Flu only), 0241U (Cepheid Xpert Xpress all targets)

CAH ORIGINAL WAIVERS

- 03/13/20.
- HHS and CMS recognize the 1135 waivers.
- Creates ability for providers to continue to serve their communities.
- Typically related to hurricane, fire, flooding, etc.
- Current blanket waivers (updated 12/01/20) 42 pages.
- https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

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PRE-WAIVER TELEHEALTH SERVICES

- Originating Sites:
  - Location where the Medicare beneficiary is provided with services through a telecommunication system in HPSA designated location.
  - Billed with revenue code 0780 with code Q3014 (paid MPFS not CAH OP).
  - Inpatient and Swing bed separately billed with TOB 012X (discharge date).
- Distant Site Practitioners employed or contracted with:
  - CMS-1500 Place of Service is 02 = Telehealth.
  - UB-04 for Method II Option of billing professional services add the GT Modifier.
  - Practitioner must be onsite.
  - Paid at 80% of allowed Medicare PFS amount (facility rate).
- CAHs don't bill both the originating and distant site on the same claim.

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TELEHEALTH WAIVERS DURING PHE

Originating Site:

- Rural requirements relaxed, can be urban.
- Not billable when patient is in their home.

Distant Site Providers:

- Can be alternate location:
  - Temporary locations – Such as tents, parking lots, non-clinic buildings or provider's home.
- Site of service is billed as the location the where the provider would normally have been scheduled to see patients.

Place of Service:

- Use POS of 11 if telehealth visit would have been a clinic visit for full reimbursement.

TELEHEALTH SERVICES FLEXIBILITY

Expansion of Provider Types - Examples Include:

- Expanded to previously ineligible physical therapist, occupational therapist, and speech pathologists
- Clinical psychologist
- Clinical social worker
- Registered dietitian or nutrition professional

Telehealth Technology:

- Should simulate in-person visit
- Technology used must be "non-public facing" (no Facebook Live or Tik Tok) Facetime, Skype are allowed under the PHE for Medicare
- Some visits are allowable as Audio-only Interaction
- Previously approved Virtual visits:
  - Telephone visits
  - E visits – Patient Portal

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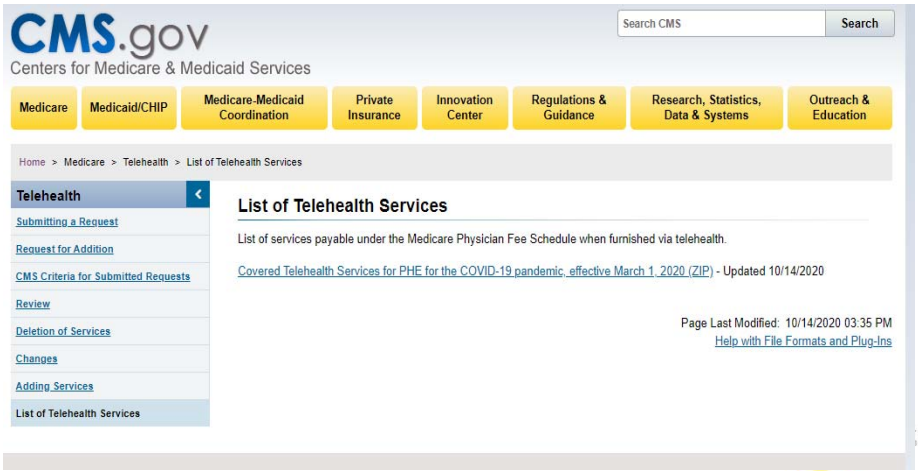
LIST OF TELEHEALTH SERVICES

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes



EXAMPLE OF LIST OF TELEHEALTH SERVICES

LIST OF MEDICARE TELEHEALTH SERVICES for PHE for the COVID-19 pandemic effective March 1 2020-updated December 1 2020				
Code	Short Descriptor	Status	Can Audio-only Interaction Meet the Requirement?	Medicare Payment Limitations
77427	Radiation tx management x5	Temporary Addition for the PHE for the COVID-19 Pandemic		
90785	Psytx complex interactive		Yes	
90791	Psych diagnostic evaluation		Yes	
90792	Psych diag eval w/med srvcs		Yes	
90832	Psytx w pt 30 minutes		Yes	
90833	Psytx w pt w e/m 30 min		Yes	
90834	Psytx w pt 45 minutes		Yes	
90836	Psytx w pt w e/m 45 min		Yes	
90837	Psytx w pt 60 minutes		Yes	
90838	Psytx w pt w e/m 60 min		Yes	
90839	Psytx crisis initial 60 min		Yes	
90840	Psytx crisis ea addl 30 min		Yes	
90845	Psychoanalysis		Yes	
90846	Family psytx w/o pt 50 min		Yes	
90847	Family psytx w/pt 50 min		Yes	
90853	Group psychotherapy		Yes	
90875	Psychophysiological therapy	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		Non-covered service
90951	Esrd serv 4 visits p mo <2yr			
90952	Esrd serv 2-3 vsts p mo <2yr	Available up Through the Year in Which the PHE Ends		
90953	Esrd serv 1 visit p mo <2yrs	Available up Through the Year in Which the PHE Ends		
90954	Esrd serv 4 vsts p mo 2-11			
90955	Esrd srv 2-3 vsts p mo 2-11			
90956	Esrd srv 1 visit p mo 2-11	Available up Through the Year in Which the PHE Ends		
90957	Esrd srv 4 vsts p mo 12-19			
90958	Esrd srv 2-3 vsts p mo 12-19			
90959	Esrd serv 1 vst p mo 12-19	Available up Through the Year in Which the PHE Ends		
90960	Esrd srv 4 visits p mo 20+			
90961	Esrd srv 2-3 vsts p mo 20+			
90962	Esrd serv 1 visit p mo 20+	Available up Through the Year in Which the PHE Ends		
90963	Esrd home pt serv p mo <2yrs			
90964	Esrd home pt serv p mo 2-11			

EXAMPLE OF LIST OF TELEHEALTH SERVICES

LIST OF MEDICARE TELEHEALTH SERVICES for PHE for the COVID-19 pandemic effective March 1 2020-updated December 1 2020				
Code	Short Descriptor	Status	Can Audio-only Interaction Meet the Requirement?	Medicare Payment Limitations
97110	Therapeutic exercises	Available up Through the Year in Which the PHE Ends		
97112	Neuromuscular reeducation	Temporary Addition for the PHE for the COVID-19 Pandemic		
97116	Gait training therapy	Temporary Addition for the PHE for the COVID-19 Pandemic		
97150	Group therapeutic procedures	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
97151	Bhv id assmt by phys/qhp	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
97152	Bhv id supvt assmt by 1 tech	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
97153	Adaptive behavior tx by tech	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
97154	Grp adapt bhv tx by tech	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
97155	Adapt behavior tx phys/qhp	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
97156	Fam adapt bhv tx gdn phy/qhp	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
97157	Mult fam adapt bhv tx gdn	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
97158	Grp adapt bhv tx by phy/qhp	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
97161	Pt eval low complex 20 min	Available up Through the Year in Which the PHE Ends		
97162	Pt eval mod complex 30 min	Available up Through the Year in Which the PHE Ends		
97163	Pt eval high complex 45 min	Available up Through the Year in Which the PHE Ends		
97164	Pt re-eval est plan care	Available up Through the Year in Which the PHE Ends		
97165	Ot eval low complex 30 min	Available up Through the Year in Which the PHE Ends		
97166	Ot eval mod complex 45 min	Available up Through the Year in Which the PHE Ends		
97167	Ot eval high complex 60 min	Available up Through the Year in Which the PHE Ends		
97168	Ot re-eval est plan care	Available up Through the Year in Which the PHE Ends		
97530	Therapeutic activities	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
97535	Self care mngment training	Available up Through the Year in Which the PHE Ends	Yes	
97542	Wheelchair mngment training	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
97750	Physical performance test	Available up Through the Year in Which the PHE Ends		
97755	Assistive technology assess	Available up Through the Year in Which the PHE Ends		
97760	Orthotic mgmt&trainig 1st enc	Available up Through the Year in Which the PHE Ends		
97761	Prosthetic traing 1st enc	Available up Through the Year in Which the PHE Ends		
97802	Medical nutrition indiv in		Yes	
97803	Med nutrition indiv subseq		Yes	
97804	Medical nutrition group		Yes	
99201	Office/outpatient visit new			

BILLING FOR OUTPATIENT THERAPY VIA TELEHEALTH – CMS FAQ

4. **Question:** Is there a graphic that can show me how to bill for outpatient therapy services furnished via telehealth during the COVID-19 Public Health Emergency?
   Answer: The below graphic demonstrates the options available to therapists who furnish physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services via telehealth or under Hospital Without Walls flexibilities.

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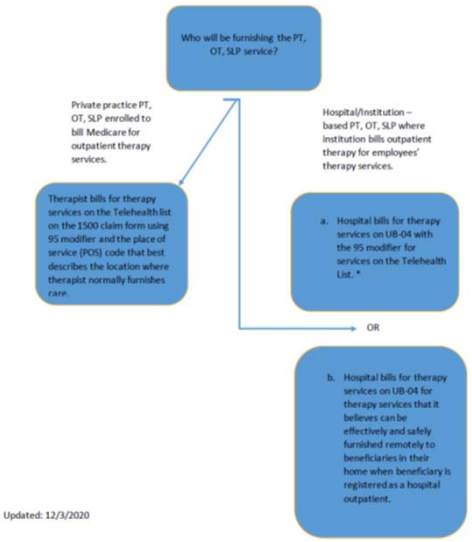
BILLING FOR OUTPATIENT THERAPY VIA TELEHEALTH – CMS FAQ



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HOSPITAL BILLING FOR REMOTE SERVICES CMS FAQ

LL. Hospital Billing for Remote Services

1. **Question:** Is there a tool that can help hospitals better understand flexibilities during the COVID-19 PHE when the beneficiary's home is serving as a provider-based department of the hospital (that is, where the hospital ensures the location meets all of the conditions of participation, to the extent not waived, and registers the beneficiary as a hospital outpatient)?
   Answer: The following graphic shows flexibilities during the COVID-19 PHE and can help inform appropriate hospital billing in such situations. Note that a telehealth service would need to be furnished by a physician or other practitioner located at a distant site in order for a hospital to bill for the originating site facility fee. Please see separate graphic and FAQs in this document on billing for therapy via telehealth.

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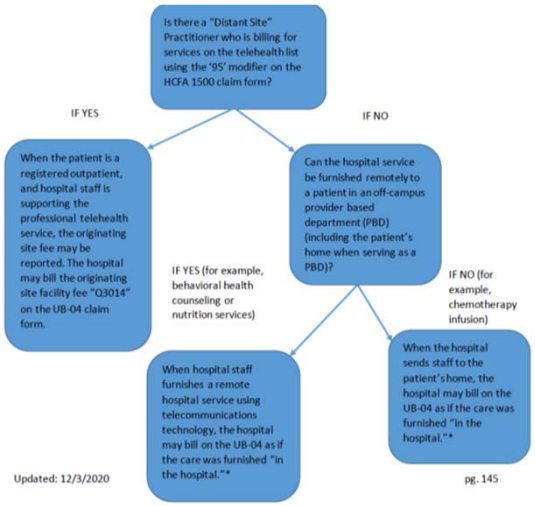
HOSPITAL BILLING FOR REMOTE SERVICES



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SWING BED WAIVERS

Waiver for 3-day qualifying stay required for Medicare coverage of Swing bed/SNF services during the PHE:

- Applies to CAH Medicare Swing bed stays as well as SNF.
- Note this requirement is only waived in the event the beneficiary experiences any of the following:
  - Evacuated from a nursing home in an emergency area.
  - Discharged early from hospital in order to provide care to more seriously ill patients.
  - Require SNF care as a result of the emergency, regardless of whether they were in a hospital or nursing home prior to the emergency.

The Waiver does not allow for billing of SNF/Swing bed services in absence of the 3-day IP qualifying stay unless there is documented proof that the requirement wasn't met as a result of COVID-19 related bed availability.

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SWING BED WAIVERS

Establishing a new benefit period: (breaking the spell of illness by being discharged to a custodial care or non institutional setting for at least 60 days):

- Dislocations resulting from the emergency may delay or prevent beneficiaries from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal circumstances.
- Utilizing authority under section 1812 of the ACT, Medicare will provide renewed coverage for extended care services which will not first require staring a new spell of illness for such beneficiaries, who can then receive up to an additional 100 days of SNF Part A coverage for care needed as a result of the previously captioned emergency. This policy will apply only for those beneficiaries who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal circumstances.

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QUESTIONS?

THANK YOU

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