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CPAs & BUSINESS ADVISORS

COVID-19 CODING AND BILLING – PART 2

January 7, 2021 | Montana Rural Health Flexibility Program

PRESENTERS

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- Information is current as of January 2021.

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ICD-10 GUIDELINES UPDATES 01/01/2021

(c) Acute respiratory manifestations of COVID-19:

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 J12.82, Pneumonia due to coronavirus disease 2019 .

e) Exposure to COVID-19

For asymptomatic individuals with actual or suspected exposure to COVID-19, assign code Z20.822, Contact with and (suspected) exposure to COVID-19.

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 Z20.822, Contact with and (suspected) exposure to COVID-19.

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ICD-10 GUIDELINES UPDATES 01/01/2021

(f) Screening for COVID-19

(f) Screening for COVID-19 During the COVID-19 pandemic, a screening code is generally not appropriate. Do not assign code Z11.52, Encounter for screening for COVID-19. 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.

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ICD-10 GUIDELINES UPDATE 01/01/2021

(i) Personal history of COVID-19

For patients with a history of COVID-19, assign code Z86.16, Personal history of COVID-19.

(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 Z86.16, Personal history of COVID-19.

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ICD-10 GUIDELINES UPDATE 01/01/2021

(I) Multisystem Inflammatory Syndrome

For individuals with multisystem inflammatory syndrome (MIS) and COVID-19, assign code U07.1, COVID-19, as the principal/first-listed diagnosis and assign code M35.81, Multisystem inflammatory syndrome, as an additional diagnosis.

If MIS develops as a result of a previous COVID-19 infection, assign codes M35.81, Multisystem inflammatory syndrome, and B94.8, Sequelae of other specified infectious and parasitic diseases.

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ICD-10 GUIDELINES UPDATE 01/01/2021

If an individual with a history of COVID-19 develops MIS and the provider does not indicate the MIS is due to the previous COVID-19 infection, assign codes M35.81, Multisystem inflammatory syndrome, and Z86.16, Personal history of COVID-19.

If an individual with a known or suspected exposure to COVID-19, and no current COVID-19 infection or history of COVID-19, develops MIS, assign codes M35.81, Multisystem inflammatory syndrome, and Z20.822, Contact with and (suspected) exposure to COVID-19.

Additional codes should be assigned for any associated complications of MIS.

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INFUSION OF CONVALESCENT PLASMA

Per CMS: Effective for hospital discharges on or after 11/2/20.

Hospitals should report the ICD-10-PCS code(s) for all products administered during the stay, regardless of whether or not the hospital received the product at no cost. Hospitals shouldn't report charges associated with the product received at no cost.

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

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VACCINE REIMBURSEMENT

Medicare Provider/Supplier[4]	Vaccine Payment Rate[5]	Vaccine Administration Payment[6]
Physician Offices	95% Average Wholesale Price	Paid separately using the established rate for the applicable administration code
Hospitals: Outpatient Departments	Reasonable Cost[7]	Paid separately using the established rate for the applicable administration code. Reasonable cost for hospitals not subject to the Outpatient Prospective Payment System.
Hospitals: Inpatient	Reasonable Cost	Paid separately using the established rate for the applicable administration code.
Skilled Nursing Facilities	Reasonable Cost	Paid separately using the established rate for the applicable administration code.

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VACCINE REIMBURSEMENT

Medicare Provider/Supplier[4]	Vaccine Payment Rate[5]	Vaccine Administration Payment[6]
Home Health Agencies	Reasonable Cost	Paid separately using the established rate for the applicable administration code.
Critical Access Hospitals (CAHs)	101% of Reasonable Cost	101% of Reasonable cost
Long-Term Care Hospitals	Reasonable Cost	Paid separately using the established rate for the applicable administration code.
Inpatient Rehabilitation Facilities	Reasonable Cost	Paid separately using the established rate for the applicable administration code.
Federally Qualified Health Centers & Rural Health Centers	Paid through the cost report process	Paid through the cost report process
Indian Health Service Hospitals & CAHs	95% Average Wholesale Price	Paid separately using the established rate for the applicable administration code.
Hospice	95% Average Wholesale Price	Paid separately using the established rate for the applicable administration code.
Home Infusion Therapy Suppliers	95% Average Wholesale Price	Paid separately using the established rate for the applicable administration code.

Updated: 12/8/20

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VACCINE ADMINISTRATION

0001A - Immunization administration by intramuscular injection of 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; first dose (Pfizer)

0002A - Immunization administration by intramuscular injection of 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; second dose (Pfizer)

0011A - Immunization administration by intramuscular injection of 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, diluent reconstituted; first dose (Moderna)

0012A - Immunization administration by intramuscular injection of 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, diluent reconstituted; second dose (Moderna)

M0239 - Intravenous infusion, bamlanivimab-xxxx, includes infusion and post administration monitoring (Eli Lilly)

M0243 - Intravenous infusion, casirivimab and imdevimab includes infusion and post administration monitoring (Regeneron)

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COVID-19 VACCINE, MONOCLONAL ANTIBODIES AND ADMINISTRATION

HCPCS/CPT Codes	Vaccine • 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 (Pfizer) • 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, diluent reconstituted, for intramuscular use (Moderna) • Q0239 - Injection, bamlanivimab-xxxx, 700 mg (Eli Lilly) • Q0243 - Injection, casirivimab and imdevimab, 2400mg (Regeneron) • Administration

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VACCINE COVERAGE AND PAYMENT

Coverage	All Medicare beneficiaries
Payment	Copayment/coinsurance waived; Deductible waived

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VACCINE PRICING

Pricing	For a COVID-19 vaccine requiring a series of 2 or more doses, the initial dose(s) administration payment rate will be $16.94, and $28.39 for the administration of the final dose in the series. Medicare payment rates for COVID-19 vaccine administration will be $28.39 to administer single-dose vaccines. For payment rates for COVID-19 vaccine administration, visit the COVID-19 Vaccines and Monoclonal Antibodies webpage on CMS. Payment for monoclonal antibody administration will be $309.60 (geographically adjusted to state/locality). Providers should not bill for the product if they received it for free. For more information on the monoclonal antibodies and their administration, visit the COVID-19 Vaccines and Monoclonal Antibodies webpage on CMS.

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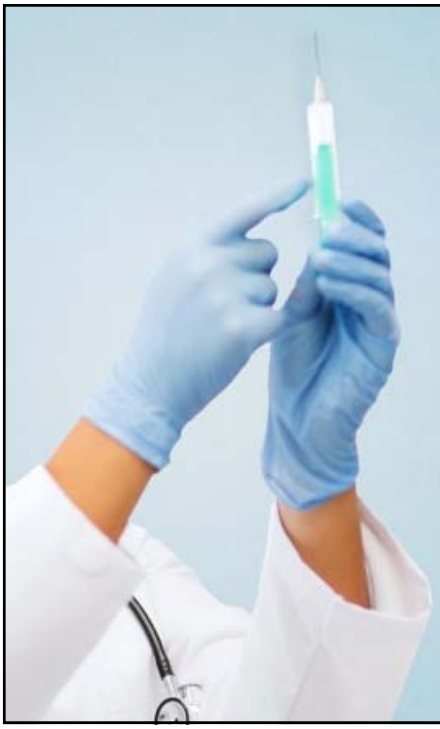

CMS MASS IMMUNIZERS

Enrollment for Administering COVID-19 Vaccine Shots

Review provider enrollment in Medicaid and CHIP information in the State Medicaid Plans toolkit

Review enrollment information for health insurance issuers and Medicare Advantage plans (PDF)

View the Enroll in Medicare to Administer COVID-19 Vaccine Shots: Information for Health Care Providers video for an overview of the enrollment process and requirements.

CMS MASS IMMUNIZERS

Are you already enrolled in Medicare?

If you're enrolled in Medicare under these institutional or non-institutional provider types, you don't need to take any action to administer and bill the COVID-19 shot, either through individual claims or roster bill, without enrolling as a mass immunizer.

Institutional	Non-Institutional
• Hospital • Hospital Outpatient Department • Skilled Nursing Facility (includes Parts A and B)* • Critical Access Hospital • End-Stage Renal Disease Facility • Home Health Agency • Hospice • Comprehensive Outpatient Rehabilitation Facility • Federally Qualified Health Center** • Rural Health Clinic*** • Indian Health Services Facility	• Physician • Non-Physician • Clinic/Group Practice • Pharmacy (enrolled as Part B) • Mass Immunizer (roster bill only)

CMS MASS IMMUNIZER

*A SNF may either administer the vaccine directly to a resident who's in a covered Part A stay or under arrangement pursuant to which the SNF pays an outside immunizer to administer the vaccine. In both these situations the SNF must bill Medicare. However, during the public health emergency, we'll allow Medicare enrolled immunizers *who are not under arrangement with the SNF* to vaccinate Medicare SNF residents and bill directly to get reimbursed from Medicare. See the recent enforcement discretion notice (PDF) for more information. For a resident in a noncovered stay, either the SNF or the immunizer not under arrangement may bill for the shot.

**Report vaccine and administration on claim informationally; we pay vaccine and administration based on reasonable cost through the cost report process.

*** We pay vaccine and administration based on reasonable cost through the cost report process.

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CMS CURRENTLY ENROLLED AS OTHER ELIGIBLE PROVIDER (E.G. PHYSICIAN/NON-PHYSICIAN, HOSPITAL, CLINIC/GROUP PRACTICE

Submit vaccination claims to Medicare (Two options):

- Roster Billing:
  - Must administer the same type of vaccine per roster claim to 5 or more people on the same date. Submit claim to specific MAC jurisdictions based on location.
- Institutional Claims (e.g. Hospital):
  - *Electronic Claims:*
  - Use Direct Data Entry
    - a. Option 02, Claims Attachment
    - b. Option 87, Roster Bill Entry
  - *Paper Claims*:
    - Use CMS-1450 (UB-04)
    - a. Contact your MAC for the roster form
- Professional Claims (e.g. Physician)
  - Electronic Claims:
    - Contact your Vendor/Clearinghouse or download free PC ACE billing software and electronically submit roster claims to your MAC.
  - Paper Claims:
    - Use Health Insurance Claim Form (CMS-1500)
    - a. Contact your MAC for the roster form

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BLUE CROSS BLUE SHIELD MONTANA BENEFICIARY INFORMATION

COVID-19 Vaccine

With a BCBSMT health plan, you have access to the COVID-19 vaccine at no cost to you. Talk with your doctor about when you should take the vaccine once available and discuss any questions you have about the vaccine.

While most plans cover the COVID-19 vaccine at no cost, some self-funded groups do not cover preventive services, including the COVID-19 vaccine. If you are unsure what your plan covers, contact your company's benefits administrator or call BCBSMT Customer Service at the number listed on your member ID card.

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MONTANA BLUE CROSS BLUE SHIELD VACCINE BILLING

Initially, the federal government will pay for the vaccine. Blue Cross and Blue Shield of Montana (BCBSMT), or self-funded groups, will cover administration of the vaccine as noted below:

Fully insured:

- Vaccine and administration covered as a preventive service with no cost-share to members at in-network providers.
- Vaccine and administration covered with no cost-share to members if delivered at out-of-network providers through the end of the public health emergency.

Self-funded employer groups:

- Non-grandfathered self-funded employer groups - vaccine and administration covered as a preventive service with no cost-share to members at in-network providers.
- Vaccine and administration covered at no cost-share to members at out-of-network providers through the end of the public health emergency.
- Self-funded employer groups that don't cover preventive vaccines through their pharmacy benefit must cover the vaccine through their medical benefit.
- Grandfathered plans are not required to cover preventive services, including the COVID-19 vaccine.

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MONTANA BLUE CROSS BLUE SHIELD VACCINE BILLING

Medicare Advantage and Medicare Supplement

For 2020 and 2021, Medicare payment for the COVID-19 vaccine and its administration will be through the original fee-for-service Medicare program.

Submit claims for administering the COVID-19 vaccine to the CMS Medicare Administrative Contractor (MAC) using product-specific codes for each vaccine approved.

Members will have no cost-sharing on vaccines through Dec. 31, 2021.

Medicaid

Most Medicaid members will have no cost-sharing on vaccines from in- and out-of-network providers. See the CMS Medicaid toolkit for more details.

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BLUE CROSS BLUE SHIELD OF MONTANA VACCINE REIMBURSEMENT AND BILLING

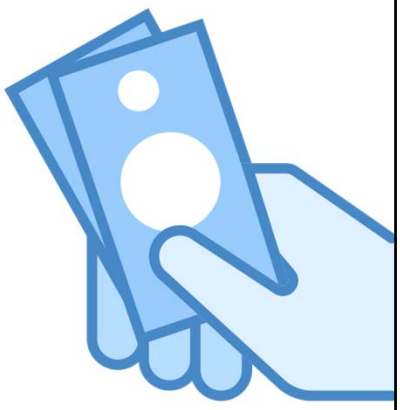
Reimbursement:

In-network providers will be reimbursed for the administration fee based on contracted rates.

Out-of-network providers will be reimbursed based on established OON reimbursement policy that follows Medicare rates

Balance billing: Providers are prohibited from billing patients for the vaccine or its administration, including balance billing, if the provider received the vaccine at no cost from the government.

Coding Claims: CMS and the AMA have identified the codes to use in submitting claims. For more information, see CMS guidance.



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BLUE CROSS BLUE SHIELD MONTANA VACCINE BILLING CODES

Code	Use	Description
91300	Vaccine	Pfizer-Biontech Covid-19 Vaccine SARSCOV2 VAC 30MCG/0.3ML IM
0001A	Admin	Pfizer-Biontech Covid-19 Vaccine Administration – First Dose ADM SARSCOV2 30MCG/0.3ML 1ST
0002A	Admin	Pfizer-Biontech Covid-19 Vaccine Administration – Second Dose ADM SARSCOV2 30MCG/0.3ML 2ND
91301	Vaccine	Moderna Covid-19 Vaccine SARSCOV2 VAC 100MCG/0.5ML IM
0011A	Admin	Moderna Covid-19 Vaccine Administration – First Dose ADM SARSCOV2 100MCG/0.5ML1ST
0012A	Admin	Moderna Covid-19 Vaccine Administration – Second Dose ADM SARSCOV2 100MCG/0.5ML2ND

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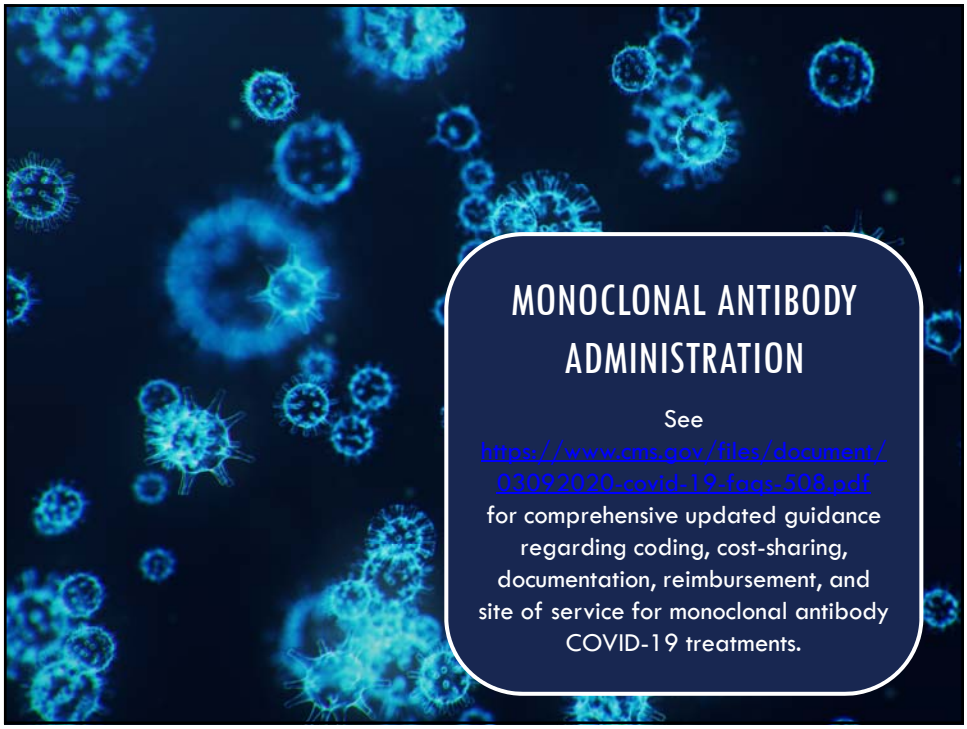

HIGH THROUGHPUT COVID-19 TESTING

- HCPCS codes U0003 and U0004 were created for Clinical Diagnostic Laboratory Tests (CDLTs) making use of high throughput technologies:
  - Technologies that use a platform that employs automated processing of more than 200 specimens a day:
    - U0003: Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R.
    - U0004: 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R.
- HCPCS code U0005 was created for an add on payment to U0003 and U0004:
  - U0005: 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, CDC or non-CDC, making use of high throughput technologies, completed within two calendar days from date and time of specimen collection. (List separately in addition to either HCPCS code U0003 or U0004).

- Payment rate for U0003 and U0004 through 2020 is $100
- Effective January 1, 2021 payment rate for U0003 and U0004 is lowered to $75
- Effective January 1, 2021 payment rate for U0005 is $25

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HIGH THROUGHPUT COVID-19 TESTING

- HCPCS code U0005 was created for an add on payment of $25; if the Lab meets the following two requirements to bill for HCPCS code U0005:
  - Lab completed the COVID-19 CDLT in 2 calendar days or less from the date of specimen collection, and
  - Majority of COVID-19 CDLTs performed using high throughput technology in the previous calendar month were completed in 2 calendar days or less for all of their patients.
    - **Not just Medicare patients**
  - HCPCS U0005 must be billed in conjunction with U0003 and U0004.
  - U0003 and U0004 reimbursed at a rate of $75. U0005 reimbursed at a rate of $25.
- If the laboratory has not completed **51%** of CDLTs for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 (for all patients) in 2 calendar days from the date the specimen was collected during the applicable month, then it may not bill for HCPCS code U0005 with either HCPCS code U0003 or U0004.

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HIGH THROUGHPUT COVID-19 TESTING

- How Labs track the 51%
  - Laboratory is submitting a claim to Medicare for a CDLT performed on high throughput technology for the detection of SARS-CoV-2 using HCPCS code U0003 with a line date of service of May 15, 2021.
  - The laboratory would assess its performance based on those CDLTs completed during the calendar month (April 1, 2021 – April 30, 2021) that precedes the month identified by the CDLT line date of service (May 2021).
  - If the laboratory completed a total of 1000 of the same CDLTs using high throughput technology (including all tests from non-Medicare patients) in April, and 490 had been completed within 2 calendar days of the specimen being collected, the laboratory would have a 49% test timeliness completion rate and may not bill for the $25 add-on payment as represented by HCPCS code U0005.
- Why was this implemented?
  - When test results are not produced within 2 calendar days of the specimen being collected, their value diminishes.

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RURAL HEALTH CLINIC

- Resource for facilities with a Rural Health Clinic (RHC):
  - MLN Matters SE20016
  - New & Expanded Flexibilities for RHCs & FQHCs during the COVID -19 PHE
- Table 1. RHC Claims for Telehealth Services from January 27, 2020, through June 30, 2020.

Revenue Code	HCPCS Code	Modifiers
052X	G2025	CG(required) 95 (optional)

- Table 2. RHC Claims for Telehealth Services starting July 1, 2020

Revenue Code	HCPCS Code	Modifiers
052X	G2025	95 (optional)

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RURAL HEALTH CLINIC

- Cost sharing related to COVID 19 Testing:
  - Services furnished March 18, 2020 through duration of PHE, Medicare will pay all reasonable costs for E/M services if they result in an order for or administration of a COVID 19 test and relate to furnishing or administration of such test or evaluate an individual for purposes of deciding need for such test. This includes applicable telehealth services.
  - For the specified E/M services related to COVID- 19 testing, including when furnished via telehealth, you must waive the collection of coinsurance from beneficiaries. For services in which Medicare waives the coinsurance, you must put the "CS" modifier on the service line. We'll pay your claims with the "CS" modifier with the coinsurance applied, and the MAC will automatically reprocess these claims beginning on July 1, 2020. Don't collect coinsurance from beneficiaries if the coinsurance is waived.

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RURAL HEALTH CLINIC

- Table 5. RHC Claims for Telehealth Services from January 27, 2020, through June 30, 2020 when cost sharing is waived:

Revenue Code	HCPCS Code	Modifiers
052X	G2025	CG CS (required) 95 (optional)

- Table 6. RHC Claims for Telehealth Services with cost sharing waived starting July 1, 2020:

Revenue Code	HCPCS Code	Modifiers
052X	G2025	CS (required) 95 (optional)

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RURAL HEALTH CLINIC

SE20016 - RHC Update December 3, 2020:

- Reprocessing G2025 Telehealth claims for coinsurance and payment calculations under the MPFS:
  - Payment should have been 80% of the lesser of the allowed amount ($92.03) or the actual charge.
  - Coinsurance should have been 20% of the lesser of the allowed amount ($92.03) or actual charges.
- Claims for distant site services G2025 were previously processed as 20% of the actual charges and the payment was processed as the allowed amount $92.03 minus the coinsurance.
- MACs will automatically reprocess any claims with CPT code G2025 for services furnished on or after 1/27/20 through November 16, 2020 for RHC Distant Site Provider Telehealth services that were paid incorrectly.

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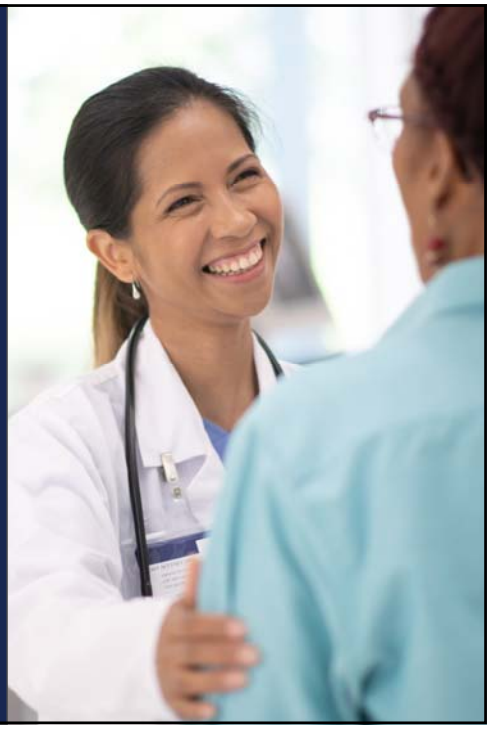
RURAL HEALTH CLINIC

SE20016 - RHC Update December 3, 2020:

- G2025 processing correctly:
  - Payment would be:
    - 20% coinsurance of $18.41 and payment of $73.62 (80% of MPFS allowed amount).
- RHCs can again expect a clean-up project with payment take-backs, repayment postings and refunding secondaries for any claims which were submitted for more than the allowed amount:
  - Note that some secondaries are paying the coinsurance amount again on these MAC reprocessed claims resulting in credit balances.



RURAL HEALTH CLINIC

Cost Reporting:

- We won't use costs for furnishing distant site telehealth services to decide the RHC AIR or the FQHC PPS rate, but these costs must be reported on the proper cost report form.
- RHCs must report both originating and distant site telehealth costs on Form CMS-222-17 on line 79 of the Worksheet A, in the section titled "Cost Other Than RHC Services".
- Medicare Advantage Wrap-Around - Since telehealth distant site services aren't paid under the RHC AIR or the FQHC PPS, the Medicare Advantage (MA) wrap-around payment doesn't apply to these services. MA plans will adjust wrap- around payment for distant site telehealth services.

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RURAL HEALTH CLINIC

Productivity Standards:

- Many RHCs have had to change the way they staff their clinics and bill for RHC services during the COVID-19 public health emergency (PHE). As a result, these RHCs may have difficulty in meeting the productivity standards. To minimize the burden on RHCs, your MAC may grant exceptions to the productivity standard during the COVID-19 PHE. Your MAC will provide further direction.

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PRICE TRANSPARENCY FOR COVID-19 DIAGNOSTIC TESTS

- Section 3202(b) of the CARES Act establishes a requirement to publicize cash prices for COVID-19 diagnostic testing during the PHE:
  - Make public the cash price for such test on a public internet website of such provider:
    - Important for plans and issuers that must comply with coverage of COVID test; and
    - For individuals who seek COVID testing.
- Tests prices to post include:
  - All *in vitro* diagnostic tests, which include molecular, antigen, and serological tests.
  - HCPCS and CPT codes including, but not limited to: CPT codes 86408, 86409, 87635, 87426, 86328, and 86769 and HCPCS codes U0001 through U0004:
    - Anticipate updating this list in guidance as new tests and codes are developed.

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PRICE TRANSPARENCY FOR COVID-19 DIAGNOSTIC TESTS

- "Cash price" is defined as the charge that applies to an individual who pays in cash (or cash equivalent) for a COVID-19 diagnostic test:
  - "Cash price" is generally analogous to the "discounted cash price" as defined at 45 CFR 180.20 for purposes of the Hospital Price Transparency final rule.
  - "Walk-in" rate that would apply to all self-pay individuals:
    - regardless of insurance status;
    - who pay in cash at the time of the service;
    - such charges are often lower than the rate the hospital negotiates with third party payers because billing self-pay individuals would not require many of the administrative functions that exist for hospitals to seek payment from third party payers (for example, prior authorization and billing functions.
  - If a provider has **not** established a "cash price" for a COVID-19 diagnostic test that is lower than its gross charge or retail rate, the provider must make public the undiscounted gross or retail rate found in its master price list (which is analogous to the hospital's chargemaster).

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PRICE TRANSPARENCY FOR COVID-19 DIAGNOSTIC TESTS

Make public cash price for COVID-19 test on provider's internet website

- Information itself, or a link to a webpage that contains such information, must appear in a conspicuous location on a searchable homepage on the provider's website.

In the event provider does not have a website on which to post cash price information

- Require the provider to make public its cash price information in writing upon request within two business days; and
- Posting signage prominently at the location where the provider offers a COVID-19 diagnostic test in a place likely to be viewed by members of the public seeking to obtain and pay for such testing.

Failure to comply may result in:

- Written warning
- Corrective Action Plan (CAP)
- Civil Monetary Penalty (CMP) if fail to respond or comply with CAP

TRACK TEMPORARY REGULATORY UPDATES

- COVID-19 Public Health Emergency prompted administration to rapidly waive or change existing Medicare regulations.
- Commercial payors responded similarly with waivers and flexibilities.
- Important to track and categorize these regulatory changes.
  - What changes did we make to systems that we need to change back
  - Future audits of claims
- Tool to track

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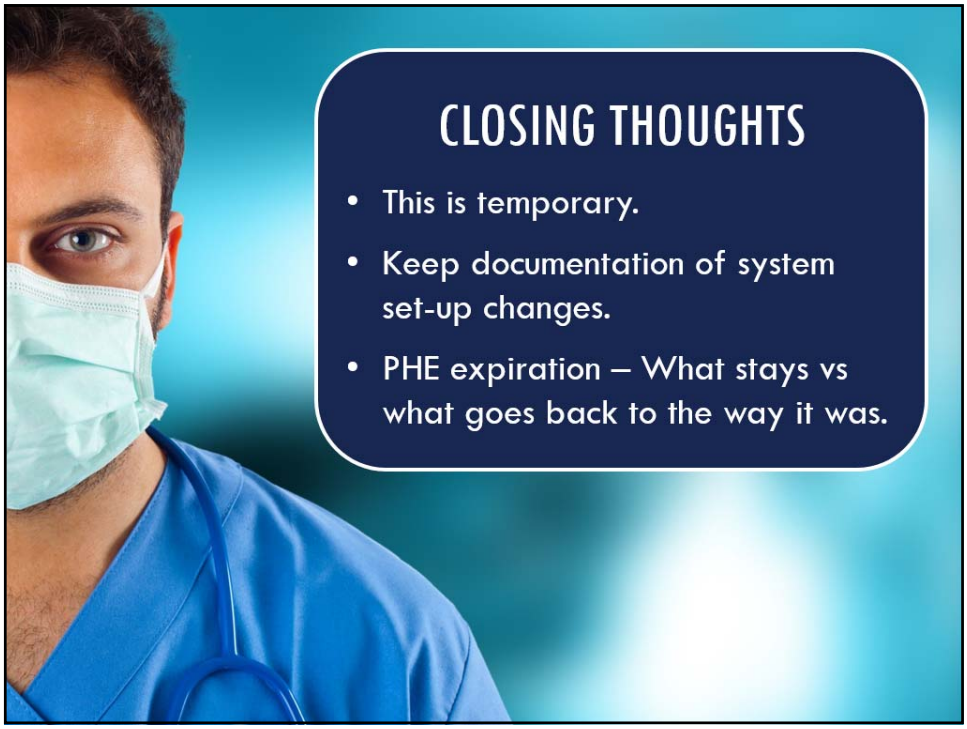
	Medicare FFS	Medicare - RHC Thru 06/30/20	Medicare - RHC Effective 07/01/20	CIGNA	Blue Shield of State
Telephone Visits (audio) 99441-99443	Yes	G2025-CG	G2025	Yes (until 5/31/20)	Payer Portal only
E-Visits & Virtual Visits (portal) G2010, G2012, 99421, 99422, 99423	Yes	Bill G0071	Bill G0071	G2012 & 99421-23 (cost sharing waived for G2012)	Payer Portal only
Telemedicine Visits Codes that are covered	https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	Bill code from FFS list as G2025-CG	G2025	E/M	E/M
Place of Service	11, 19, 22 Location regularly scheduled Provider Based: Q3014	If regularly scheduled to be seen in RHC bill Revenue Code 0521	If regularly scheduled to be seen in RHC bill Revenue Code 0521	11	02
Modifiers	95 (telehealth)	CG	N/A	95 or GT	States none required in one area & can add 95 in another
COVID-19 Screening	Cost Sharing waived if CS Modifier is appended	Cost Sharing waived if CS Modifier is appended	Cost Sharing waived if CS Modifier is appended	Cost Sharing waived when test is ordered as a result of encounter	Cost Sharing waived only if diagnosis code U07.1 is on the claim



QUESTIONS?

THANK YOU

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