

## DISCLAIMER

This document is intended to provide a consolidated update on the rapidly shifting changes in regulatory requirements related to COVID-19. Guidance on specific patient care or documentation and billing/coding workflows being implemented at UCM are separate and not covered in this document. To access the most current version of this document, click here: <http://compliance.bsd.uchicago.edu/>

### March 22, 2020: CMS Announces Exceptions and Extensions for Clinicians Participating in Quality Reporting Programs

#### [COVID-19 UPDATES](#)

March 23, 2020:

[CMS Provider Enrollment FAQs](#)

March 22, 2020:

[CMS extends quality reporting deadlines](#)

March 20, 2020:

[AAMC letter to CMS](#)

March 19, 2020:

[Indiana Executive Order 20-05](#)

March 19, 2020:

[AAMC letter to Congress and VP](#)

March 19, 2020:

[HFS 1135 waiver application](#)

March 18, 2020:

[Families First Coronavirus Response Act signed into law](#)

March 18, 2020:

[ICD-10 adopts WHO diagnosis code U07.1 \(COVID-19\)](#)

March 17, 2020:

Medicare Telemedicine [Fact Sheet](#) and [FAQs](#)

March 16, 2020:

[HFS Coronavirus and Expanded Care Options](#)

March 13, 2020:

[CMS' activation of blanket waivers](#)

March 13, 2020:

[FAQ on coverage benefits](#)

March 12, 2020:

[FAQ for State Medicaid and CHIP](#)

March 10, 2020:

[FAQ on State Survey Agencies](#)

March 10, 2020:

[MAP and Part D guidance](#)

March 9, 2020:

[EMTALA reminder](#)

March 9, 2020:

[Telehealth benefits](#)

March 6, 2020:

[emergency funding](#)

As part of the Trump Administration's response to COVID-19, CMS is implementing additional extreme and uncontrollable circumstances policy exceptions and extensions for upcoming measure reporting and data submission deadlines for the following CMS programs. For details of *all* affected programs, see CMS' [Press Release](#).

#### Provider Programs:

- Quality Payment Program-Merit-based incentive payment system (MIPS)
  - 2019 deadline extended from 3-31-20 to 4-30-20
  - Clinicians who do not meet the new deadline will qualify for the automatic extreme and uncontrollable circumstances policy and will receive a neutral payment adjustment for the 2021 MIPS payment year.
  - CMS is evaluating options for providing relief around participation and data submission for 2020.

#### Hospital Programs

- Hospital-Acquired Condition Reduction Program
- Hospital Outpatient Quality Reporting Program
- Hospital Readmissions Reduction program
- Hospital Value-Based Purchasing Program
  - Deadlines for October 1, 2019 – December 31, 2019 (Q4) data submission optional.
  - If Q4 is submitted, it will be used to calculate the 2019 performance and payment (where appropriate). If data for Q4 is unable to be submitted, the 2019 performance will be calculated based on data from January 1, 2019 – September 30, 2019 (Q1-Q3) and available data.
  - For 2020 data submission, for the *Hospital-Acquired Condition Reduction Program and the Hospital Value-Based Purchasing Program*, if data from January 1, 2020 – March 31, 2020 (Q1) is submitted, it will be used for scoring in the program (where appropriate)
  - For 2020 data submission, MS will not count data from January 1, 2020 through June 30, 2020 (Q1-Q2) for performance or payment programs. Data does not need to be submitted to CMS for this time period.

### March 19, 2020: Executive Order Allows Providers Licensed in Another State to Provide Care in Indiana

Indiana's Governor Gov. Holcomb issued [Executive Order 20-05](#). The order allows health care providers licensed in another state to provide care in Indiana, as well as greater flexibility for Indiana Medicaid in using telemedicine to administer some services. UCMC providers can provide Indiana patients with telehealth services from a licensure perspective. Illinois and Wisconsin haven't taken action yet, however, Illinois is less of a concern since our providers are already licensed in Illinois. Providers are still restricted from providing telehealth services to patients physically located in Wisconsin until Wisconsin takes similar action.

### March 19, 2020 the Dept. of Healthcare and Family Services submitted an Illinois 1135 Waiver Request to CMS

On March 19, 2020, the Dept. of Healthcare and Family Services (HFS) submitted a request to the Centers for Medicare & Medicaid Services (CMS) to waive certain federal Medicaid, Children's Health Insurance Program (CHIP), and Health Insurance Portability and Accountability Act (HIPAA) regulations during the COVID-19 public health emergency. If approved, this Section 1135 waiver would apply to services provided to Medicaid and CHIP beneficiaries under the fee-for-service and managed care programs. Highlights of the Section 1135 waiver request include:

- Waive the requirement that physicians and other healthcare professionals are licensed in the State of Illinois to serve Illinois Medicaid beneficiaries within Illinois or out-of-state, so long as they have an equivalent license in another state or Veterans Affairs or are enrolled in Medicare;
- Allow physicians to bill as the teaching physician when real-time audio video or access through a window is provided when hospitals are running low on supplies to limit the number of providers with direct patient contact
- Permitting Medicaid payment for hospital outpatient observation services up to 48 hours, if not longer;
- Allowing prescribers not enrolled with Medicaid to write prescriptions for Medicaid patients; and
- Allowing non-HIPAA compliant telehealth modes for telehealth visits or check-ins at the location of the patient and certain waiving HIPAA sanctions and penalties for noncompliance.

Please see the HFS Section [1135 Waiver Letter](#) and related [fact sheet](#) for a complete list of waiver requests. **These flexibilities are still subject to CMS approval.**

### The Families First Coronavirus Response Act (H.R. 6201) Signed Into Law March 18, 2020

The Families First Coronavirus Response Act (H.R. 6201) was signed into law on March 18, 2020. Healthcare coverage will be impacted as follows:

- Group health plans, health insurance issuers, Medicare Advantage plans, TRICARE, veterans plans, federal workers' health plans and the Indian Health Service would be required to cover, at no cost to the patient, the COVID-19 diagnostic test. They would also be required to cover the patient's visit to a provider, urgent care center or emergency room to receive the testing.
- States would be permitted to extend Medicaid eligibility to their uninsured populations for COVID-19 diagnostic testing.

[bill](#)  
**March 6, 2020:**  
[Covid-19 FAQs](#)  
**March 5, 2020:**  
[2<sup>nd</sup> HCPCS code for COVID-19 tests](#)  
**March 4, 2020:** [call to action to providers](#)  
**Feb 13, 2020:**  
[new HCPCS code for COVID-19 test](#)  
**Feb 6, 2020:**  
[lab guidance](#)  
**Feb 6, 2020:**  
[memo to healthcare facilities](#)  
**Jan 31, 2020:**  
[HHS Secretary declared a public health emergency](#)

- The Secretary of HHS shall be providing a **claims modifier** to be used so that **COVID-19 testing related services (such as below)** will be identifiable on the Medicare claim for purposes of a specified outpatient payment methodology that will be applied.
  - Office and other outpatient services
  - Hospital observation services
  - Emergency department services
  - Nursing facility services
  - Domiciliary, rest home, or custodial care services
  - Home services
  - Online digital evaluation and management services.

## Released March 17, 2020: CMS Releases Details Regarding Expansion of Medicare Emergency Telehealth Services

### EMERGENCY TELEHEALTH WAIVER

On March 17, 2020, CMS provided a [fact sheet](#) and [FAQs](#) which further clarifies the Medicare telehealth services that beneficiaries can receive under the President’s emergency declaration announced on March 13, 2020. Initial changes to Medicare Telehealth were triggered on March 6, 2020 when President Trump signed into law the emergency funding bill “Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020” which extended payment for telehealth services to all Medicare beneficiaries regardless of geographical location. Prior to this, the Social Security Act limited telehealth services to beneficiaries receiving care at authorized originating sites located mostly in rural areas. See CMS’ [Telehealth Services manual](#) for details on Original Telehealth.

### Highlights from the CMS Fact Sheet and FAQs regarding Medicare Telehealth Services:

- **No geographic or site restrictions:** Waiver of geographical restrictions for originating sites, allowing providers to provide telehealth services to patients from any location, including the patient’s home or any setting of care.
- **Smart Phones:** Telecommunication systems may include phones so long as they have audio and video capabilities (e.g., smart phone, face-time, Zoom) which allows for two-way, real-time interactive communication as long as it is not public facing (such as Facebook Live).
- **All Medicare Telehealth Services may be billed, not just services related to COVID-19:** Common telehealth services include 99201-99215 (Office or other outpatient visits), G0425-G0427 (Telehealth consultations, ED, or initial patient), G0406-G0408 (Follow-up inpatient telehealth consultations). For a complete list, go to CMS’ [List of Telehealth Services](#).
- **New or Established Patients:** Telehealth may be provided for **\*new or established patients** (prior communication from CMS originally restricted Telehealth to established patients)  
*\*To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.*

Providers are also reminded that in addition to Medicare telehealth services which are meant to take the place of a face-to-face office visit, they may also use Virtual Check-In codes (i.e., brief telephone call that mitigates the need for an in-person visit) and E-visit codes (patient-provider evaluation provided via MyChart) as described at the end of this newsletter.

## Released March 17, 2020: HHS OIG Waives Telehealth Cost-Sharing During COVID-19

- The Department of Health and Human Services (HHS) Office of Inspector General (OIG) announced in its [Policy Statement](#) on March 17, 2020 that it would not impose administrative sanctions on physicians or other practitioners who reduce or waive cost-sharing for Federal health care program beneficiaries for telehealth services furnished during the COVID-19 public health emergency, which has existed since January 27, 2020. [OIG’s guidance applies to all telehealth services furnished to Federal health care program beneficiaries during the COVID-19 public health emergency, and is not limited to telehealth services related to patients with COVID-19.](#)
- OIG clarified that it will not bring an enforcement action under either the Federal anti-kickback statute or the beneficiary inducements civil monetary penalty statute for waiving or reducing such cost-sharing, provided all applicable CMS payment and coverage rules are met. Nothing in the Policy Statement requires a reduction or waiver of such cost-sharing amounts, nor does it otherwise affect a physician or practitioner’s responsibility to comply with other applicable laws and regulations.

## Released March 13, 2020: COVID-19 Emergency Declaration Health Care Providers Fact Sheet

President Trump’s declaration on March 13, 2020 of a national emergency due to COVID-19 gave CMS the authority to waive certain Medicare, Medicaid, and CHIP program requirements and conditions of participation under Section 1135 of the Social Security Act (“1135 waivers”). As a result, the following blanket waivers are available:

- **Provider Locations:** Temporarily waive requirements that out-of-state providers be licensed in the state where they are providing services when they are licensed in another state. This applies to Medicare and Medicaid.
  - **Provider Enrollment:** Establish a toll-free hotline for non-certified Part B suppliers, physicians and non-physician practitioners to enroll and receive temporary Medicare billing privileges; waive the following screening requirements:
    - Application Fee – 42.CFR 424.514
    - Criminal background checks associated with FCBC – 42 CFR424.518
    - Site visits- 42 CFR424.517
- Postpone all revalidation actions and expedite any pending or new applications from providers  
 - \*Allow licensed providers to render services outside of their state of enrollment

**\*NOTE:** This extends only to Medicare and Medicaid enrollment and reimbursement qualifications but it does not loosen restrictions on state licensure issues which require the provider to be licensed in the state in which the patient is located. States are continuing to waive licensure requirements as the situation evolves. We will keep you up to date if Illinois or surrounding states invoke this waiver.

- **Medicare appeals in Fee for Service, MA and Part D:** Extension to file an appeal and waiver of timelines for requests for additional information to adjudicate the appeal.
- **Skilled Nursing Facilities:** CMS is waiving the requirement for a 3-day prior hospitalization for coverage of a skilled nursing facility stay to provide temporary emergency coverage of SNF services without a qualifying hospital stay for those people who need to be transferred as a result of the effect of a disaster or emergency.

For details, see [COVID-19 Emergency Declaration Health Care Providers Fact Sheet](#):

## Coverage of COVID-19 Testing and Treatment by non-Medicare Payors

**MEDICAID (updated 3/23/20):** The [Provider Notice issued 3/20/20](#), describes changes to telehealth policy due to the current public health emergency related to COVID-19. These changes apply to claims billed for participants covered under fee-for-service as well as a HealthChoice Illinois managed care plan.

**Telehealth Services:** Telehealth services are medically necessary and clinically appropriate services covered under the Medical Assistance Program as set forth in [89 Ill. Adm. Code section 140.3](#) that are delivered using a communication or technology system to a patient at an originating site by a provider located at a distant site. The Department will reimburse telehealth services with dates of service on or after March 9, 2020 until the public health emergency no longer exists, when delivered using:

1. an *“interactive telecommunication system” (means audio and video equipment permitting two-way, real-time communication; does not include telephone, fax machine or email) or “telecommunication system” (means an asynchronous store and forward technology and/or an interactive telecommunication system that is used to transmit data between the originating and distant sites; does not include telephone calls, fax machines and text messages without visualization of the patient (electronic mail) (as described in \*89 Ill. Admin. Code Section 140.403(a), or;*
2. a communication system where information exchanged between the physician or other qualified health care practitioner and the patient during the course of the synchronous telehealth service is of an amount and nature that would be sufficient to meet the key components and requirements of the same service when rendered via face-to-face interaction.

**Originating Site Changes:** Any site that allows for the patient to use a communication or technology system as defined above may be an originating site, **including a patient’s place of residence** located within the state of Illinois or other temporary location within or outside the state of Illinois. An originating site will be eligible for a facility fee when it is a certified eligible facility or provider organization that acts as the location of the patient at the time a telehealth service is rendered. A physician or other licensed health care professional is not required to be present at all times with the patient at the originating site.

**Distant Site Changes:** The distant site provider is any enrolled provider, operating within their scope of practice, and with the appropriate license or certification.

**Reimbursement:** Telehealth payment rates are the same as face-to-face services provided on-site. The distant site provider and originating site provider eligible for a facility fee must maintain adequate documentation of the telehealth services provided in accordance with the record requirements of section [140.403\(d\)](#).

**Non-telehealth services:** The Department will also reimburse for the following services during this public health emergency, including:

- **Virtual Check-in** – A brief communication technology-based service that uses audio-only real-time telephone interactions or synchronous, two-way audio interactions that are enhanced with video or other kinds of data transmission. Virtual check-ins must be rendered by a physician or advance practical nurse, or physician assistant who can report evaluation and management (E/M) services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment. The Department will reimburse for \*CPT codes 99441-99443 at the rate established on the Department’s Practitioner Fee Schedule to all providers listed above.  
*\*Note: CPT codes 99441-99443 are for telephone E/M codes whereas Virtual Check-in code is G2012. OCC is inquiring with HFS to determine if HFS meant to refer to G2012, rather than codes 99441-99443 with regards to reimbursement.*
- **Online patient portal or “E-visit”:** These services are non-face-to-face patient-initiated communications using online patient portals. These services can only be reported when the billing practice has an established relationship with the patient. For these encounters, the patient must generate the initial inquiry and communications can occur over a 7-day period. The patient must verbally consent to receive virtual check-in services. The Department will reimburse for HCPCS codes G2061-2063 and CPT codes 99421-99423 at the rate established on the Department’s Practitioner Fee Schedule to all providers listed above.
- **Behavioral Health Services:** Notwithstanding [89 Ill. Adm. Code 140.6\(m\)](#) and [140.403](#), the Department will reimburse for all behavioral health services detailed in [140.453](#) (except for Mobile Crisis Response and Crisis Stabilization as defined in [140.453\(d\)\(3\)](#)) and behavioral health services contained on an applicable Department fee schedule provided using audio-only real-time telephone interactions, or video interaction. Federally Qualified Health Centers, Rural Health Clinics, and Encounter Rate Clinics will receive their encounter rate.

## [BlueCross BlueShield of Illinois](#) (link and content updated 3/23/20):

**COVID-19 Testing:** Members won't pay copays, deductibles or coinsurance for testing to diagnose COVID-19 or for testing-related visits with in-network providers, whether at a provider's office, urgent care clinic, emergency room or by telehealth.

**Telehealth:** Members can access provider visits for covered services through telemedicine or telehealth as outlined in their benefit plan or employer's self-funded plan. Members won't pay copays, deductibles, or coinsurance on in-network covered telemedicine or telehealth services. Depending on their benefits, members may have access to services through two-way, live interactive telephone and/or digital video consultations, and virtual visits powered by MDLIVE.

## [AETNA](#) (link and content updated 3/23/20):

**COVID-19 testing:** Aetna is waiving co-pays and applying no cost-sharing for all diagnostic testing related to COVID-19. This policy will cover the cost of a physician-ordered test and the physician visit that results in a COVID-19 test, which can be done in any approved laboratory location. Aetna will waive the member costs associated with diagnostic testing for all Commercial, Medicare and Medicaid lines of business. The policy aligns with new Families First legislation requiring all health plans to provide full coverage of COVID-19 testing without cost share. The requirement also applies to self-insured plans.

**For the next 90 days, until June 4, 2020, Aetna will waive member cost sharing for any covered telemedicine visits – regardless of diagnosis:** Cost sharing will be waived for all virtual visits through the Aetna-covered Teladoc® offerings and in-network providers. Self-insured plan sponsors will be able to opt-out of this program at their discretion.

**Aetna is also offering its Medicare Advantage brief virtual check-in and remote evaluation benefits to all Aetna Commercial members and waiving the co-pay.** These offerings will empower members with questions or concerns that are unrelated to a recent office visit and do not need immediate in-person follow-up care to engage with providers without the concern of sitting in a physician's office and risking potential exposure to COVID-19.

## [HUMANA:](#)

**COVID-19 testing.** Testing for COVID-19 will be fully covered with no out-of-pocket costs for patients who meet CDC guidelines at approved laboratory locations. This applies to members of Humana's Medicare Advantage, Medicaid and commercial employer-sponsored plans. The CDC continues to offer free testing for coronavirus.

**Telemedicine visits for all urgent care needs are fully covered.** To help reduce the risk of infection and spread of disease, Humana is encouraging members to use telemedicine (e.g., video chat) as a first line of defense for all urgent care needs. Humana will waive out-of-pocket costs for telemedicine visits for urgent care needs for the next 90 days. This will apply to Humana's Medicare Advantage, Medicaid and commercial employer-sponsored plans, and is limited to in-network providers delivering live video-conferencing. Humana is working closely with federal agencies to understand the impacts of both telemedicine and the coronavirus test on High Deductible Health Plans and Health Savings Accounts.

## [United Healthcare](#) (content updated 3/23/20)

**COVID-19 testing:** United Healthcare is waiving cost sharing for COVID-19 testing and related visits, whether the testing related visits is received in a health care provider's office, an urgent care center, an emergency department or through a telehealth visit. This coverage applies to Medicare Advantage, Medicaid and employer-sponsored plans.

### **Telehealth resources:**

- **24/7 Virtual Visits through designated telehealth providers:** These visits can be useful in determining if a member should call their local health care provider regarding COVID-19 testing, and are also ideal for urgent care treatment of other illnesses, like the seasonal flu, allergies, pink eye and more. Medicare Advantage and Medicaid members can continue to access their existing telehealth benefit offered through designated partners without cost sharing. Cost sharing for members with a telehealth benefit through their employer-sponsored plan will be waived through June 18, 2020.
- **Local telehealth visits with your medical provider:** Telehealth visits with a member's health care provider can be used for both COVID-19 and other health needs. For COVID-19 testing related telehealth visits with a health care provider, cost-sharing is waived during this national emergency. For other health related telehealth visits, cost sharing and coverage will apply as determined by the members health benefits plan, through June 18, 2020.

## [Cigna](#) (content updated 3/23/20)

**COVID-19 diagnostic visits:** Cigna is waiving out-of-pocket costs for COVID-19 visits with in-network providers, whether at a provider's office, urgent care center, emergency room, or via virtual care, through May 31, 2020.

**COVID-19 testing:** Cigna is waiving out-of-pocket costs for COVID-19 FDA-approved testing. Only a health care provider or hospital can administer the test and send the sample to an approved lab for results.

**COVID-19 treatment:** Your plan will cover treatment associated with COVID-19 or similar diseases. Out-of-pocket costs may apply.

**COVID-19 Virtual Care Visits:** For a virtual visit related to screening, diagnosis, or testing for COVID-19, out-of-pocket costs will be waived

**Non-COVID-19 Virtual Care Visits:** Members can also receive virtual medical care not related to COVID-19 by physicians and certain providers with virtual care capabilities through May 31, 2020. Out-of-pocket costs may apply.

[Illinicare](#)- Illinicare directs members to this [link](#) about COVID-19 and Aetna Providers. See Aetna section above for details.

[Countycare](#) – Countycare's site currently does not speak to any changes in coverage with respect to COVID-19.

On March 18, 2020, [ICD-10-CM announced](#) that it would adopt the World Health Organization (WHO) code **U07.1 (COVID-19)**, effective **April 1**.

### Confirmed Cases of COVID-19

- Code U07.1 as the primary code
- Pneumonia and all other manifestations should also be coded.

### Concern about exposure to COVID-19

For cases where there is concern about a possible exposure to COVID-19, but this is ruled out after evaluation,” report code **Z03.818** (Encounter for observation for suspected exposure to other biological agents ruled out), the CDC instructs.

### Actual exposure to a confirmed case of COVID-19

Report code **Z20.828** (Contact with and [suspected] exposure to other viral communicable diseases).

### Signs/symptoms

When the patient is exhibiting signs and symptoms but a definitive diagnosis has not been established, the CDC instructs that you code only the presenting signs and symptoms, such as:

- **R05** (Cough),
- **R06.02** (Shortness of breath) or
- **R50.9** (Fever, unspecified).

**Prior to April 1:** Providers can continue to report based on [previously published interim guidelines](#), which outlines, among other things, how to report illnesses caused by COVID-10 with two codes. For example:

#### Bronchitis

- Acute bronchitis due to COVID-19: Assign code **J20.8** (Acute bronchitis due to other specified organisms and B97.29).
- Bronchitis not otherwise specified (NOS) caused by COVID-19: **J40** (Bronchitis not specified as acute or chronic) and code B97.29.

#### Lower respiratory infection

- Lower respiratory infection, not otherwise specified (NOS) or acute respiratory infection caused by COVID-19: Report code **J22** (Unspecified acute lower respiratory infection) and code B97.29.
- Respiratory infection NOS caused by COVID-19: Code **J98.8** (Other specified respiratory disorders) and code B97.29.

#### Acute respiratory distress syndrome (ARDS)

- ARDS due to COVID-19: Report codes **J80** (Acute respiratory distress syndrome) and code B97.29.

**MEDICARE HCPCS CODES:** Medicare claims processing systems can accept these new codes starting 4-1-20 for dates of service on or after 2-4-20.

- **U0001** Released 2-6-20; applies to CDC’s 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel Assay. For authorized CDC testing laboratories to test patients for SARS-CoV-2. NGS Payment Rate is \$35.91.
- **U0002:** Released 3-5-20; allows labs to bill for non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19). NGS Payment Rate is \$51.31

**AMA CPT CODE:** Effective 3-13-20, a new CPT code is available for novel coronavirus testing by hospitals, health systems and labs in the U.S. The CPT Editorial Panel approved the code at a special, expedited meeting held Friday, march 13, 2020.

- **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

Resources:

- [AMA CPT Announcement](#) of new code
- [AMA Fact Sheet](#) for CPT Code 87635

## AVAILABLE CODES THAT PROVIDERS CAN USE DURING COVID-19 PUBLIC HEALTH EMERGENCY

NAME OF CODE	REQUIREMENTS	EXAMPLES
<p><b>Medicare Emergency Telehealth Services</b></p> <p>These are services that would normally be provided in –person but CMS allowed them to be conducted via telecommunication technology for patients who lived in rural areas. Under the current COVID-19 Emergency Act, the geographic restrictions have been lifted. Providers select the appropriate telehealth service from CMS’ <a href="#">List of Telehealth Services</a>.</p> <p>Common examples:</p> <ul style="list-style-type: none"> <li>• New Outpatient Visit 99201-99205</li> <li>• Est Outpatient Visits 99211-99215</li> <li>• G0425-G0427 (Telehealth consultations, emergency department or initial inpatient)</li> <li>• G0406-G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs)</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Billing Providers:</b> Physicians, Nurse practitioners, Physician Assistants, Certified nurse midwives, as well as certified nurse anesthetists, licensed clinical social workers, clinical psychologists, an registered dietitians or nutrition professionals within their scope of practice and consistent with Medicare benefit rules that apply to all services.</li> <li>• <b>Patient Type:</b> <u>new and established patients</u>; services do not have to be related to COVID-19 under the waiver</li> <li>• <b>Telecommunication Technology:</b> Technology that has audio and video capabilities that are used for two-way, real-time interactive communication as long as it is not public facing (such as Facebook Live). <u>This includes Zoom, FaceTime, Smart phones, and mobile computing devices.</u> Audio/video capabilities must be available but providers do not have to use it. The Office for Civil Rights will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patient in good faith through such everyday communications technologies like Skype and FaceTime.</li> <li>• <b>Billing for Service:</b> Medicare telehealth services are generally billed as if the service had been furnished in-person. The claim should reflect the designated Place of Service (POS) code 02-Telehealth to indicate the billed service was furnished as a professional telehealth service from a distant site.</li> <li>• <b>Medicare payment for telehealth services:</b> Starting March 6, 2020, and for the duration of the COVID-19 Public Health Emergency, Medicare will</li> </ul>	<p><b>CPT 99212:</b> Patient requests appointment with physician to discuss pain he has been having in right arm. Visit is conducted between Physician and patient via Skype. Physician collects HPI, ROS, PMFH and documents the visit as he would have for an in-person visit. He includes a statement that more than 50% of time was spent in counseling. Provider bills 99213 based on total time spent during visit.</p>

	<p>make payment for Medicare Telehealth Services furnished to patients in broader circumstances. These are paid at the same amount as it would if the service were furnished in person.</p> <ul style="list-style-type: none"> <li>• <b>Beneficiary out of pocket costs:</b> While telehealth does not change out of pocket costs for beneficiaries with Original Medicare (e.g., deductible and coinsurances), the OIG is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.</li> <li>• <b>On-site visits conducted via video or through a window in the clinic suite:</b> Services should only be reported as telehealth services when the individual physician or professional providing the telehealth service is not at the same location as the beneficiary.</li> </ul>	
<p><b><u>HCPCS G2012- Virtual Check-In</u></b></p> <p>Brief (5-10 minutes) medical discussion via communication technology-based service between a patient and qualified health care professional. The purpose of these calls is to determine if a follow-up visit is required.</p>	<ul style="list-style-type: none"> <li>• <b>Billing Providers:</b> those who can bill E/M (physicians/ NPs/PAs). Telephone calls completed by clinical office staff do not qualify for use of this code.</li> <li>• <b>Patient Type:</b> <u>Established patients only</u></li> <li>• <b>Locations:</b> All locations, including patient’s home</li> <li>• <b>Related E/M Services:</b> Service can bear no relation to an E/M service within the prior seven days, or result in an E/M service within the ensuing 24 hours (or soonest appointment).</li> <li>• <b>Technology:</b> Real-time, two-way audio only (i.e., <u>telephone</u>); may be enhanced with video or other data transmission (excludes voice messages- must be a live conversation).</li> <li>• <b>Initiation:</b> Patient initiates service</li> <li>• <b>Time Requirements:</b> 5–10 minutes of medical discussion required.</li> <li>• <b>Frequency:</b> No frequency limitation; CMS will monitor frequency to determine whether a limit is necessary</li> <li>• <b>Documentation:</b> Provider documents date, time, duration of service along with brief summary of topic(s) discussed.</li> <li>• <b>Consent:</b> patient must verbally consent to receive check-in services (Medicare co-insurance and deductibles would apply)</li> </ul>	<p>Patient calls provider about a cough. This is a patient seen in the last year. The call lasts 7 minutes during which the provider determines the patient does not need to be seen in person. Provider documents the service in the record and bills G2012.</p>
<p><b><u>HCPCS G2010-Remote Evaluation of Prerecorded Patient Information</u></b></p> <p>Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours</p>	<ul style="list-style-type: none"> <li>• <b>Distinctly separate service from G2012.</b></li> <li>• <b>Billing Providers:</b> those who can bill E/M (physicians/ NPs/PAs).</li> <li>• <b>Patient Type:</b> <u>Established patients only</u></li> <li>• <b>Locations:</b> All locations, including patient’s home</li> <li>• <b>Technology:</b> Follow-up may take place via phone call, audio/video communication, secure text messaging, email, or patient portal communication. Such communication must be compliant with HIPAA and other relevant laws.</li> <li>• <b>Initiation:</b> Patient initiates service</li> <li>• <b>Related E/M Service:</b> Service can bear no relation to an E/M service within the prior seven days, or result in an E/M service within the ensuing 24 hours (or soonest appointment).</li> <li>• <b>Frequency:</b> No frequency limitations; CMS will monitor utilization.</li> <li>• <b>Documentation:</b> Provider documents review and interpretation of images and also date and time of beneficiary contact and content discussion. When the quality of the prerecorded information is insufficient to allow the clinician to assess the need for medical treatment, the service may not be billed.</li> <li>• <b>Consent:</b> patient must verbally consent to receive check-in services (Medicare co-insurance and deductibles would apply)</li> </ul>	<p>Patient that the provider has seen in the past 3 years, texts a picture of a rash to the provider. Provider calls the patient within 24 hours to recommend OTC cream. No follow-up visit is required. Provider documents the service in the record and bills G2010.</p>
<p><b><u>Online Digital Evaluation and Management Services (e-Visit)</u></b></p> <p>For Physicians and qualified healthcare practitioners that can bill E/M codes, online digital E/M service, cumulative time</p>	<ul style="list-style-type: none"> <li>• <b>New codes as of CY20 Physician Fee Schedule Final Rule</b></li> <li>• <b>E-Visit Definition:</b> non-face-to-face “patient-initiated digital communications that require a clinical decision that otherwise typically would have been provided in the office.”</li> <li>• <b>Billing Providers:</b> CPT codes 99421-99423 are reserved for physicians and other healthcare practitioners that can directly bill Medicare E/M codes. CMS created HCPCS codes G2061, G2062, and G2063 for non-physician practitioners who are unable to bill E/M services.</li> <li>• <b>Patient Type:</b> <u>Established patients only</u></li> </ul>	<p>Established patient contacts primary care provider via MyChart with complaints about fatigue and flu-like symptoms. Provider reviews medical history, formulates diagnosis, treatment</p>

<p> <b>99421:</b> 5-10 min up to 7 days  <b>99422:</b> 11-20 min up to 7 days  <b>99423:</b> 21 or more min up to 7 days         </p> <p> <b>Non-physician practitioners who are unable to bill E/M services.</b>  <b>G2061:</b> 5-10 min up to 7 days  <b>G2062:</b> 11-20 min up to 7 days  <b>G2063:</b> 21 or more minutes up to 7 days         </p>	<ul style="list-style-type: none"> <li>• <b>Locations:</b> All locations, including patient’s home</li> <li>• <b>Digital Service:</b> electronic health record portal, secure email or other digital applications</li> <li>• <b>Initiation:</b> Patient initiates service via digital platform, but follow-up by the provider may include telephone.</li> <li>• <b>Related E/M Services:</b> If the patient had an E/M service within the last seven days, or has a face 2 face E/M visit related to the problem in the next 7 days, these codes may not be used.</li> <li>• <b>Frequency:</b> Services may only be reported once in a 7-day period. Clinical staff time may not be counted.</li> <li>• <b>Consent:</b> patient must verbally consent to receive check-in services (Medicare co-insurance and deductibles would apply)</li> </ul>	<p>plan, and sends in prescription. Provider calls patient to discuss plan. This totals 15 minutes over 7 days. Provider documents service in the record, and bills CPT code 99422.</p>
<p> <b>Telephone evaluation and management visits</b> by a physician or QHCP who may report E/M services         </p> <p>           99441 5-10 min            99442 11-20 min            99443 21-30 min         </p> <p> <b>Telephone assessment and management services</b> by a qualified non-physician health care professional who may not report E/M services         </p> <p>           98966 5-10 min            98967 11-20 min            98968 21-30 min         </p>	<ul style="list-style-type: none"> <li>• <b>NOTE:</b> these codes are not paid by Medicare currently</li> <li>• <b>Billing Provider 99441-99443:</b> Physicians and QHCP who may report E/M services</li> <li>• <b>Billing Provider 98966-98968:</b> Non-physician who may not report E/M services (e.g. speech-language pathologists, physical therapists, occupational therapists, social workers, dieticians)</li> <li>• <b>Patient Type:</b> <u>Established patient only</u></li> <li>• <b>Locations:</b> All locations, including patient’s home</li> <li>• <b>Initiation:</b> Patient must initiate service</li> <li>• <b>Related E/M Services:</b> may not originate from a related E/M service provided in the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment</li> <li>• <b>Consent:</b> patient must verbally consent to receive check-in services (Medicare co-insurance and deductibles would apply)</li> </ul>	<p>Established patient to the provider/specialty calls and speaks to physician regarding flu-like symptoms. Provider spends 10 minutes in medical discussion and ultimately tells the patient to stay home and rest, drink fluids. No follow-up face to face E/M visit needed. Provider documents service in the record and bills 99441.</p>