FAQ: COVID-19 Revenue Cycle Webinar

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Revenue Cycle Solutions

Note: The following represents a series of questions received following our recent webinar. The responses detailed reflect information available at the time of the query. Wherever possible we have included links with our answers for consideration. We encourage you to review the links in addition to our answer. Please be aware that conditions are fluid and information may have changed after these questions were addressed.

Question: In your interpretation of these RHC billing guidelines, can the telemedicine visits be audio-only as is allowed for non-RHC visits?

Answer: The interim Final Rule addressing the COVID-19 Public Health Emergency (PHE) states CMS will reimburse physicians based on the RVUs associated with the Physician Fee Schedule. That section of the Interim Final Rule beginning on page 122 and clarifying reimbursement for telephone services does not include exceptions for RHCs or FQHCs. The telehealth guidance that does provide RHC and FQHC exceptions specifically excludes audio only.
https://www.cms.gov/files/document/covid-final-ifc.pdf

Question: Can you bill for facility IOP services or professional services only. If we can bill for the facility do, we just use the regular CPT codes with modifier 95 and Rev code 780? I appreciate any help you can give.

Answer: Only professional providers on the list of eligible practitioners can perform telehealth services. Per CMS, there is no facility component of any telehealth service.

https://www.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf:

"13. Q: Can hospitals, nursing homes, home health agencies or other healthcare facilities bill for telehealth services?

A: Billing for Medicare telehealth services is limited to professionals. (Like other professional services, Critical Access Hospitals can report their telehealth services under CAH Method II). If a beneficiary is in a health care facility (even if the facility is not in a rural area or not in a health professional shortage area) and receives a service via telehealth, the health care facility would only be eligible to bill for the originating site facility fee, which is reported under HCPCS code Q3014. "

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Question: I was on the CMS call last week and was lucky enough to get in the question queue and asked about provider-based billing and was told we could. Can you confirm if this is consistent with what you are hearing? I understand right now situations are very fluid.

Answer: I have been on several calls when this is asked, and the respondent responded yes but added that services can be billed and paid under physician fee schedule. Each time it appeared the CMS respondent was addressing the professional component of provider-based services even though to hospitals it was clear the question was intended to explain the facility component. During a recent call this was asked several times and the same answer was given even though each subsequent question clarified they were not asking about the professional component. Finally, someone asked specifically if G0463 was acceptable for the hospital component of telehealth and the answer came back submit the question in writing. Clear guidance was not provided.

- A review of the list of eligible providers does not include Outpatient hospitals, and G0463 - Hospital outpatient clinic visit, for assessment and management of a patient has not been added as a covered telehealth service: https://www.cms.gov/files/zip/covid-19-telehealth-services-phe.zip

- The interim Final Rule published March 31 gives guidance on professional billing only: https://www.cms.gov/files/document/covid-final-ifc.pdf
  "we are instructing physicians and practitioners who bill for Medicare telehealth services to report the POS code that would have been reported had the service been furnished in person…"

- Nothing in writing has approved billing the facility component. Everything in writing states there is no facility component. The calls can be misleading which is why I request everything in writing. The April 7 call specifically stated other than the transcript nothing would be published clarifying guidance.

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Question: I am not able to find the reference that we cannot provider-base bill telehealth. Can you give me a link?

Answer: There are several references that provide this guidance but this one is the most definitive:

https://www.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

13. Q: Can hospitals, nursing homes, home health agencies or other healthcare facilities bill for telehealth services?

A: Billing for Medicare telehealth services is limited to professionals. (Like other professional services, Critical Access Hospitals can report telehealth services under CAH Method II). If a beneficiary is in a health care facility (even if the facility is not in a rural area or not in a health professional shortage area) and receives a service via telehealth, the health care facility would only be eligible to bill for the originating site facility fee, which is reported under HCPCS code Q3014.

Question: I am looking for documentation on telehealth billing new patient visits and how this will affect meaningful use

Answer: I have not seen any guidance regarding Meaningful Use. I will forward any updates that may be provided.

Question: I had one question that I was hoping you all might be able to help me with. We bill as a CAH method II facility and I know from the one slide that we still use the GT modifier but are we supposed to use both GT and 95 or just GT?

Answer: You would report either modifier 95 or GT for Telehealth. Since you bill Method II (UB-04) use modifier GT. You will also need modifier CR and Condition Code DR for services related to waivers. If the service includes waiver of cost sharing add modifier CS.

If you need all 3 modifiers, I suggest ordering them with the modifier that affects reimbursement first, then the more specific informational modifier then the broader informational modifier:
CS,GT,CR

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Question: I cannot find any other information about the A7 modifier, and was hoping you had the CMS reference that discusses this?

Answer: I sent a question to CMS on March 26 asking how hospitals should report screening services performed in the parking lot. I got the following response:

DCN: 20086063001061

Dear Laurie Daigle:

Thank you for your e-mail received on March 26, 2020. You wrote to us regarding mobile units for COVID crisis. You wanted a reference regarding billing for mobile units.

You may access information regarding mobile facilities in MM11470 using the following link:

https://www.cms.gov/files/document/mm11470

Question: Since Medicare pays us at 100% for lab services –would you recommend we add the CS modifier on these lab service lines? Or should this only be used for services were the patient cost share does apply?

Answer: The FAMILIES FIRST CORONAVIRUS RESPONSE ACT (FFCRA) applies to all payors and specifically states

"Therefore, for example, if the individual's attending provider determines that other tests (e.g., influenza tests, blood tests, etc.) should be performed during a visit (which term here includes in-person visits and telehealth visits) to determine the need of such individual for COVID-19 diagnostic testing, and the visit results in an order for, or administration of, COVID-19 diagnostic testing, the plan or issuer must provide coverage for the related tests under section 6001(a) of the FFCRA. This coverage must be provided without cost sharing, when medically appropriate for the individual, as determined by the individual's….

May a plan or issuer impose any cost-sharing requirements, prior authorization requirements, or medical management requirements for benefits that must be provided under section 6001(a) of the FFCRA, as amended by section 3201 of the CARES Act?

No"

For this reason, I would advise adding CS modifier to all affected charge lines. Medicare will probably ignore this on lab claims but other payors may need it to properly process labs.

I hope this helps.

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Question: Can you provide some detail surrounding use of the CR Modifier?

Answer: The guidelines for requirement of CR modifier and CR condition code keep changing. Examples include:

FAQ released April 9th,
https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf?inf_contact_key=79530e2a4eea4f25d95665fd4500e31d680f8914173f9191b1c0223e68310bb1

"Question: Regarding the use of the condition code "DR" and modifier "CR", should these codes be used for all billing situations relating to COVID-19 waivers?

Answer: Yes. Use of the "DR" condition code and "CR" modifier are mandatory for institutional and non-institutional providers in billing situations related to COVID-19 for any claim for which Medicare payment is conditioned on the presence of a "formal waiver" (as defined in the CMS Internet Only Manual, Publication 100-04, Chapter 38, § 10). The DR condition code is used by institutional providers only, at the claim level, when all the services/items billed on the claim are related to a COVID-19 waiver. The CR modifier is used by both institutional and non-institutional providers to identify Part B line item services/items that are related to a COVID-19 waiver."

This conflicts somewhat with SE20011 revised April 10 which states:

"https://www.cms.gov/files/document/se20011.pdf
The "DR" (disaster related) condition code for institutional billing, i.e., claims submitted using the ASC X12 837 institutional claims format or paper Form CMS-1450.
2. The "CR" (catastrophe/disaster related) modifier for Part B billing, both institutional and non-institutional, i.e., claims submitted using the ASC X12 837 professional claim format or paper Form CMS-1500 or, for pharmacies, in the NCPDP format.

As a reminder, CMS is not requiring the CR modifier on telehealth services."

The update dated April 15 fails to mention the exemption for telehealth:

https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf
"Claims Submission for Blanket Waivers:
When submitting claims covered by the blanket waivers, the "DR" (disaster-related) condition code should be used for institutional billing (i.e., claims submitted using the ASC X12 837 institutional claims format or paper Form CMS-1450). The "CR" (catastrophe/disaster-related) modifier should be used for Part B billing, both institutional and non-institutional (i.e., claims submitted using the ASC X12 837 professional claim format or paper Form CMS-1500 or, for

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pharmacies, in the NCPDP format). This requirement does not apply for purposes of compliance with waivers (blanket or individual) of sanctions under the physician self- referral law."

I wish I could say with some degree of certainty CMS was done, but several changes have been made to this transmittal. For now, I say DR condition code is required for institutional claims and , and modifier CR is required for all Part B billing both institutional and non-institutional. Telehealth may be an exception.

Question: Does CMS Telehealth guidance apply to Urgent Care Center?

Answer: I have not seen payor specific guidance for urgent care centers. Medicare has allowed outpatient visits for new patients under expanded Public Health Emergency (PHE) guidelines. The guidance also states you should report the place of service where the service would have taken place absent the PHE. There is nothing in the guidance that precludes urgent care centers from these guidelines:

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
https://www.cms.gov/files/document/se20011.pdf

Question – How should a FQHC report telemedicine?

Answer: As I discussed in the presentation, FQHCs have been approved as distant site telehealth providers as of March 30, but the secretary had not provided billing and reimbursement guidance.

CMS released guidance in MLN Matters publication SE20016 on April 17, 2020
https://www.cms.gov/files/document/se20016.pdf

"Payment to RHCs and FQHCs for distant site telehealth services is set at $92, which is the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS.

For telehealth distant site services furnished between January 27, 2020, and June 30, 2020, RHCs and FQHCs must put Modifier "95" (Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System) on the claim. RHCs will be paid at their all-inclusive rate (AIR), and FQHCs will be paid based on the FQHC Prospective Payment System (PPS) rate. These claims will be automatically reprocessed in July when the Medicare claims processing system is updated with the new payment rate. RHCs and FQHCs do not need to resubmit these claims for the payment adjustment. For telehealth distant site services furnished between July 1, 2020, and the end of the PHE"

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Question – How should we determine Medicaid billing guidelines for telemedicine?

Answer: Each Governor sets state specific guidelines for Medicaid waivers during the PHE. Almost every state has a COVID-19 PHE link to billing guidance on their Medicaid home page. Federal approvals for state wavier requests can be found at:

https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/federal-disaster-resources/index.html
https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/home-community-based-services-public-heath-emergencies/emergency-preparedness-and-response-for-home-and-community-based-hcbs-1915c-waivers/index.html

Question: Should we be billing the hospital component of a physician telehealth ED visit?

Answer: CMS has reiterated there is no reimbursable facility component of a telehealth service. The emergency room physician should report the service on the appropriate billing form with ED place of service on a 1500 or Revenue Code 981 to report Method II critical Access professional services. The hospital cannot report a charge.

- A review of the list of eligible providers does not include Outpatient hospitals, and G0463 - Hospital outpatient clinic visit, for assessment and management of a patient has not been added as a covered telehealth service: https://www.cms.gov/files/zip/covid-19-telehealth-services-phe.zip

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  "we are instructing physicians and practitioners who bill for Medicare telehealth services to report the POS code that would have been reported had the service been furnished in person…"

- Nothing in writing has approved billing the facility component. Everything in writing states there is no facility component. The calls can be misleading which is why I request everything in writing. The April 7 call specifically stated other than the transcript nothing would be published clarifying guidance.

If the patient is in an originating site separate from the provider, the originating site cans still bill Q3014

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Question: Where can I find RHC specific guidance?

Answer: Guidance for reporting PHC and FQHC telehealth services is published in the PHE Interim Final Rule published March 31, 2021:

https://www.cms.gov/files/document/covid-final-ifc.pdf

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Question: Where might I find information regarding use of telehealth in an Independent Urgent Care centers?

Answer: I have not seen payor specific guidance for urgent care centers. Medicare has allowed outpatient visits for new patients under expanded Public Health Emergency (PHE) guidelines. The guidance also states you should report the place of service where the service would have taken place absent the PHE. There is nothing in the guidance that precludes urgent care centers from these guidelines:

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
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Question: Can you tell me if Diabetic RN's are allowed to conduct telehealth or can they only do virtual visits?

Answer: Telehealth is a professional service, not a hospital or OPPS service. Diabetic RNs that bill under an ordering provider's NPI are not eligible for telehealth reimbursement. NPs that provide diabetes self education management and bill under their own NPI can act as the distant site provider for Medicare. Other payors vary. Medicare allows Diabetic RNs to perform telephone assessment and management services and report the time-based codes below if the documentation warrants

98966: 5-10 minutes
98967: 11-20 minutes
98968: 21-30 minutes

Registered Dieticians and nutrition professionals are on the list of Distant site practitioners who can furnish and get payment for covered telehealth services. This has been interpreted to mean providers that are bill under their own NPI and are eligible for reimbursement

Question : Will Medicare update their guidance to include Physical and Occupational Therapist for telehealth?

Answer: I can't say they will update their guidance, but on a recent call CMS acknowledged this was the most common concern being address during calls and emails. It was stated this is under review, but nothing has been published to approve these providers for telehealth during the PHE

Question: When assigning COVID modifiers, what is the sequencing standard?

Answer: The order should be modifiers that impact reimbursement followed by informational modifiers

For example
Telehealth Office visit 99213 qualifying for waived cost sharing:
99213,CS,95

Question: How do we report CS modifier to ensure the payor waives cost sharing and pays the allowed amount in full?

Answer: Answer: The guidance on this was first released on April 7:

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https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-07-mlnc-se

Changed on April 10:
https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-10-mlnc-se#_Toc37418832

And clarified and amended on April 11 n an FAQ
https://www.cms.gov/files/document/FFCRA-Part-42-FAQs.pdf

Putting all these together, the current guidance states all payors should waive cost sharing for

- A visit resulting in the "*an order for, or administration of, COVID-19 diagnostic testing,"*
- The COVID-19 test, administration of the test and any packaging and conveyance necessary
- Tests for other causes of respiratory illness (e.g. rapid flu, other blood work)

All individual lines eligible for waiver of cost sharing should be appended with modifier CS. If the service was also a telehealth service report either modifier 95 for services billed on 1500 or modifier GT for services billed on a UB as CAH Method II professional billing. There is no technical (facility component) of a telehealth visit unless the patient is in a medical facility serving as the originating site. Additional guidance was released several times and as of now, finally clarified on April 10 to state that institutional claims (UBs) should also condition code DR for all claims with services related to COVID 19.

Medicare Billing Scenarios:

- Method II telehealth: report GT modifier and DR condition code
- Method II telehealth (non RHC) visit with cost sharing: modifiers CS,GT and DR condition code
- Method II non-telehealth, or Hospital bill with waiver of cost sharing: CS modifier and DR condition code.
- Non-Method II telehealth: modifier 95 on 1500. Use the POS associated with the place where the service would have been performed in person absent a Public Health Emergency. If you choose to bill POS 02 for telehealth, Medicare will reimburse the facility component of the Physician Fee Schedule.
- Non-Method II telehealth with waiver of cost sharing: Modifiers CS,95. Use the POS associated with the place where the service would have been performed in person

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absent a Public Health Emergency. If you choose to bill POS 02 for telehealth, Medicare will reimburse the facility component of the Physician Fee Schedule.

Question: Virtual check in vs initiated by the patient? what is the difference?

Answer: Virtual check-in visits require store and forward technology capabilities, meaning recorded video or images to be evaluated must be transmitted and stored in the patient record. Although this service is described as time based, there is only one code available for RHCs and one code available for non RHCs, so the guidelines basically require a minimum of 5 minutes of practitioner time:

G2010 - 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, 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

G0071 - Payment for communication technology-based services for 5 minutes or more of a virtual (nonface-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images

Question: I would like to know more about when to use DR condition Code and CR modifier. Is this still needed with all the changes that have taken place to telehealth?

Answer: As of April 15, 2020, Modifier CR is not required for telehealth services. Since Public Health Emergency waivers now affect non-telehealth services for waiver of cost sharing, CS modifier may be required for non-telehealth services impacted by the Public Health Emergency. Condition code DR is required for institutional claims impacted by the COVID-19 Public Health Emergency. Guidance on this modifier and condition code has changed at least 3 times since March 17. Each time MLN SE20011 has been updated. Check the link below frequently for guidance:
https://www.cms.gov/files/document/se20011.pdf

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Answer: The order should be modifiers that impact reimbursement followed by informational modifiers

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All individual lines eligible for waiver of cost sharing should be appended with modifier CS. If the services were also telehealth services report either modifier 95 for services billed on 1500 or modifier GT for services billed on a UB as CAH Method II professional billing. There is not technical (facility component of a telehealth visits unless the patient is in a medical facility serving as the originating site. Additional guidance was released several times and as of now, finally clarified on April 10 to state that institutional claims (UBs) should also condition code DR for all claims with services related to COVID 19.

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- Non-Method II telehealth: modifier 95 on 1500. Use the POS associated with the place where the service would have been performed in person absent a Public Health Emergency. If you choose to bill POS 02 for telehealth, Medicare will reimburse the facility component of the Physician Fee Schedule.
- Non-Method II telehealth with waiver of cost sharing: Modifiers CS,95. Use the POS associated with the place where the service would have been performed in person absent a Public Health Emergency. If you choose to bill POS 02 for telehealth, Medicare will reimburse the facility component of the Physician Fee Schedule.

Question: How should we bill RHC telehealth services?

Answer:

a. Bill Commercial payors according to the individual payor guidance and append modifier 95. If the visit is eligible for waver of cost sharing, then also bill modifier CS on each eligible line
b. Bill Medicaid according to State Medicaid requirements If the visit is eligible for waver of cost sharing for example spend-down), then also bill modifier CS on each eligible line

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c. Medicare released information April 17 requiring *Modifier "95" (Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System) on the claim. RHCs will be paid at their all-inclusive rate (AIR), and FQHCs will be paid based on the FQHC Prospective Payment System (PPS) rate. These claims will be automatically reprocessed in July when the Medicare claims processing system is updated with the new payment rate of $95.00. RHCs and FQHCs do not need to resubmit these claims for the payment adjustment.*

Question: In what order should modifiers be applied

Answer – Medicare has not assigned an order, but I would bill modifier CS first since it impacts payment and informational modifier, either 95 for 1500s, or GT for Method II

Q: Should we append modifier CS to every line of a visit if the Visit includes and order for COVID-19 testing?

Answer: Not necessarily.

On April 7 CMS indicated we should append modifier CS to the visit line if the visit resulting an order for or administration of a COVID 19 test, or evaluation for the purpose of determining the need for the test. On April 10, additional clarification waived cist sharing for ***certain*** COVID-19 testing-related services.

CS should be appended to goods or services related to **evaluation of such individual for purposes of determining the need of the individual for the product, as determined by the individual's attending healthcare provider.** In order to apply waiver if cost sharing.

This is vague and confusing but seems to indicate that only services necessary to support decision to perform COVID-19 test (the product) should be appended with modifier CS and should waive cost-sharing.

Question: Which modifier comes first if I need to report a telehealth visit resulting in a COVID-19 test?

Answer: CMS is not clear, but I would assign the modifier that impacts reimbursement first and the informational only modifier second , so CS,95 or CS,GT

Question: Why doesn't CMS allow Therapists to perform telehealth?

Answer: CMS has not provided information supporting this decision but on a recent call the representative shared this is the number one issue for which they receive feedback, and this is under review. Look for possible changes moving forward.

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