PARA HealthCare Analytics

MHA Business Ventures – COVID-19 CODING Q/A Webinar

April 24, 2020

PARA HealthCare Analytics | HEALTHCARE FINANCIAL RESOURCES

Who We Are – What We Do – Our Mission

- Founded in 1985
- National Client Base
- Trusted Partnerships

PARA is comprised of individuals with extensive experience in focused disciplines to support the revenue cycle process.

PARA is a proven resource for the following:

- Pricing
- Coding
- Reimbursement
- Compliance

PARA's mission is to provide a comprehensive single source solution that meets the needs of the revenue cycle team, to be recognized as an industry leader in delivering value and measurable results and to lead the healthcare market in improving financial management in the delivery of care.

COVID-19 QUESTIONS

Preface -- New regulations and billing instructions are evolving as the country reacts to the extraordinary, unprecedented COVID-19 National Health Emergency.

The information provided herein is a good faith attempt to assist providers with information derived from research conducted using public information resources.

COVID-19 QUESTIONS

Question: Is there or will there be a code for recent travel history?

Answer: No, there is currently not a code for "recent travel history"? There is no current information indicating a code will be created for "recent travel history". However, it is possible that will change.

COVID-19 QUESTIONS

Question: OP testing for COVID – negative result. Code symptoms of fever, SOB, etc. first and then Z03.818?

Answer: For cases where there is a concern of a possible exposure to COVID-19, but this is ruled out after evaluation, report Z03.818, Encounter for observation for suspected exposure to other biological agents ruled out. Signs and symptoms may be reported as secondary codes

For an actual exposure to someone who is confirmed or suspected (not ruled out) to have COVID-19, and the exposed individual either tests negative or the test results are unknown, report Z20.828, Contact with and (suspected) exposure to other viral communicable diseases.

COVID-19 QUESTIONS

Question: We had a patient that came in and got tested on 4/8/2020. This result came back positive:

- So the 4/8/2020 visit should be coded U07.1 correct?
- Then patient comes back 4/20/2020 for a follow up visit and a retest which is negative. How do I code the office visit.
- Is it a follow up code with the U07.1

Answer: The initial visit with a positive COVID-19 test is reported with U07.1. The second visit with a negative test is reported as a follow up (Z09), with an additional code for personal history of infectious disease (Z86.19)

Note: Add CS modifier to both encounters during which testing was ordered.

COVID-19 QUESTIONS

Question: If patient comes in for office visit and gets test done which returns a positive result is it necessary for the doctor to go back into the note and document a positive result was returned?

Answer: Yes, the provider documentation is essential as coders cannot code from lab findings alone.

COVID-19 QUESTIONS

Question: We are looking for some billing guidance. What telemedicine services are covered, how should they be billed (UB vs 1500). Looking for nutritional services, Physical Therapies, etc.

Answer: RD's and "nutrition professionals" are permitted to provide telehealth services – but services must be billed on a professional fee claim form (with the exception of a Method II CAH, which reports professional fees on a UB04/837i.)

- Professionals must be enrolled with Medicare (or other payor.)
- The list of Medicare telehealth services is available at https://www.cms.gov/files/zip/covid-19-telehealth-services-phe.zip
- Enrolled professionals may report the HCPCS on the CMS telehealth list so long as they are performing services within their scope of licensure under state law.

COVID-19 QUESTIONS

Question: For Telehealth services billed on a 1500, do you want the place of service listed as 02? In addition, do you have modifiers that you want on the charges as well?

Answer: It depends on the payor.

- Medicare has instructed providers to report the POS that would have been reported had the visit been face-to-face. If the provider would normally report POS 11, the higher non-facility rate will be paid.
- Some payors are instructing providers to report POS 02.
- Different payors may require different modifiers; BCBS Montana has instructed GT or GQ (see next slide.)

BCBS Montana

BlueCross BlueShield of Montana

How are telemedicine services identified on a professional claim billed on a 1500?

For Commercial and Healthy Montana Kids (HMK) claims, providers should indicate originating place of service 2 (telemedicine). Additionally, to expedite claims, BCBSMT asks providers to add modifiers GQ or GT on lines of service not identified as telemedicine within the code description.

(Example: CPT 99212 (In-Office E/M visit) performed by video/audio platform would require a GQ or GT modifier.)

For Medicare Advantage, providers should follow CMS' current guidance for telemedicine claims.

https://www.bcbsmt.com/provider/education-and-reference/news?lid=k8cxumar

COVID-19 QUESTIONS

Question: In order to have the cost shares waived for COVID-19 related, these insurances want the CS modifier, or will you use the Dx to evaluate this?

Answer: Payor policies may vary.

- For Medicare, the CS modifier alone will identify services relating to testing for COVID-19 which are not subject to patient cost-sharing.
- Providers should document the evaluation of whether to test for COVID within the visit record, as the actual test may not be billed on the same claim.
- In addition, the letter of the law allows payment for a COVID test evaluation even if the decision not to test is recorded.

BCBS Montana

BlueCross BlueShield of Montana

Blue Cross and Blue Shield of Montana (BCBSMT) is waiving member cost-sharing, including deductibles, copayments and coinsurance related to **treatment** for COVID-19. The waiver applies to costs associated with COVID-19 treatment at in-network facilities and treatment for out-of-network emergencies.

Which members are included?

The new policy applies to all fully insured group plan, individual and family plan, Medicare (excluding Part D plans), and Healthy Montana Kids (HMK), and Medicare Supplement members. Many of our members are covered under a health plan that is self-insured by their employer. Some of these members may be responsible for copay or deductibles, based on their employer's election to participate in this benefit.

How Long will cost sharing be waived?

The policy is effective for treatment received April 1, 2020, through May 31, 2020. We will reassess this policy as circumstances warrant.

How to Submit COVID-19 Treatment Claims

Submit your claims for COVID-19 treatment of confirmed cases of COVID-19 using **ICD-10 code U07.1**.

COVID-19 QUESTIONS

Question: For MHC what do you need on the claim to indicate either testing or treatment of COVID-19 to waive the cost sharing?

Answer: Payor policies vary. Medicare requires only modifier CS.

COVID-19 QUESTIONS

Question: BCBS mentions condition code DR and CR modifiers to indicate COVID-19 related claim. Is that in place and is the more guidance on when to use it?

Answer: We have not found mention of condition code DR or modifier CR on the BCBS Montana website.

- Medicare requires condition code DR on facility fee claims which represent services that were rendered under a National Health Emergency waiver, such as “Hospitals without Walls.”
- Modifier CR is required on pro fee claim lines, and facility fee outpatient claim lines, which represent services rendered under a federal waiver to address the National Health Emergency.

Condition Code DR, Modifier CR

https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

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 of 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. New: 4/10/20

COVID-19 QUESTIONS

Question: The state is performing the tests at no charge so our charge is captured with a $0 charge. Is there any other way to indicate that we tested during that encounter? Diagnosis or anything like that?

Answer: For Medicare, providers are not required to report the test code with the evaluation code related to the decision to test for COVID-19. The CS modifier will suffice.

However, if appropriate, you may consider ICD10 Z20.828: *Contact with and (suspected) exposure to other viral communicable diseases*

COVID-19 QUESTIONS

Question: In billing for Physical Therapy and Occupational Therapy would you need to add any additional modifiers to reflect treatment being done via telehealth? Are there separate codes that would need billed out?

Answer: Physical, occupational, and speech language pathologists may not report the true "telehealth" services; they are limited to reporting:

- eVisits (G2061 – G2063)
- Virtual Check-Ins (G2010, G2012)
- Telephone services (98966 – 98968)
- Must be enrolled as an individual and bill on a professional fee claim form

Remote Professional Services

- Telehealth – real time audio/visual communications
- E-Visits – via a patient portal
- “Virtual Check-Ins” – internet, phone
- Telephone Services

RHC's/FQHC's

- For Medicare, the RHC/FQHC may report G0071
- Or, the individual RHC providers may report any of the telehealth codes on a professional fee claim form
- Account for costs of RHC provider generating professional fees for remote services separately in the cost report.

- https://www.cms.gov/index.php/regulations-and-guidanceguidancetransmittals2020-transmittals/se20016

Code of Federal Regulations

TITLE 42 / CHAPTER 7 / SUBCHAPTER XVIII / Part B / § 1395l

https://uscode.house.gov/view.xhtml?req=(title:42%20section:1395l%20edition:prelim)

(cc) Specified COVID–19 testing-related services

For purposes of subsection (a)(1)(DD):

(1) Description

(A) In general

A specified COVID–19 testing-related service described in this paragraph is a medical visit that-

(i) is in any of the categories of HCPCS evaluation and management service codes described in subparagraph (B);

(ii) is furnished during any portion of the emergency period (as defined in section 1320b–5(g)(1)(B) of this title) (beginning on or after March 18, 2020);

(iii) results in an order for or administration of a clinical diagnostic laboratory test described in section 1395w–22(a)(1)(B)(iv)(IV) of this title; and

(iv) relates to the furnishing or administration of such test **or** to the evaluation of such individual for purposes of determining the need of such individual for such test.

CARES Act Provisions - continued

SEC. 4201. Coverage of diagnostic testing for COVID-19 - continued

(b) CLAIMS MODIFIER.—The Secretary of Health and Human Services shall provide for an appropriate modifier (or other identifier) to include on claims to identify, for purposes of subparagraph (DD) of section 1833(a)(1), as added by subsection (a), specified COVID–19 testing-related services described in paragraph (1) of section 1833(cc) of the Social Security Act, as added by subsection (a), for which payment may be made under a specified outpatient payment provision described in paragraph (2) of such subsection.

Modifier CS

Append modifier CS to HCPCS (professional fee and facility fee) reporting COVID–19 testing- related services (encounters that result in a provider's decision to test for COVID-19), including:

- 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.

CARES Act Provisions - continued

- **SEC. 4202. Pricing of diagnostic testing.**
- (a) Reimbursement rates.—A group health plan or a health insurance issuer providing coverage of items and services described in section 201(a) with respect to an enrollee shall reimburse the provider of the diagnostic testing as follows:
  - (1) If the health plan or issuer has a negotiated rate for such service with such provider, such negotiated rate shall apply.
  - (2) If the health plan or issuer does not have a negotiated rate for such service with such provider, such plan or issuer shall reimburse the provider in an amount that equals the cash price for such service as listed by the provider on a public internet website.

CARES Act Provisions - continued

- **SEC. 4202. Pricing of diagnostic testing.**
- (b) Requirement to Publicize Cash Price for Diagnostic Testing for COVID-19.—
  - (1) IN GENERAL.—**Each provider of a diagnostic test for COVID-19 shall make public the cash price for such test on a public internet website of such provider.**
  - (2) CIVIL MONETARY PENALTIES.—The Secretary of Health and Human Services may impose a civil monetary penalty on any provider of a diagnostic test for COVID-19 that is not in compliance with paragraph (1) and has not completed a corrective action plan to comply with the requirements of such paragraph, in an amount not to exceed $300 per day that the violation is ongoing.

CARES Act Provisions - continued

DRG Reimbursement Increased for IPPS Hospitals

(No provision for increased inpatient reimbursement for CAHs)

https://www.cms.gov/files/document/se20015.pdf

Inpatient Prospective Payment System (IPPS) Hospitals –

Section 3710 of the CARES Act directs the Secretary to increase the weighting factor of the assigned Diagnosis-Related Group (DRG) by 20 percent for an individual diagnosed with COVID-19 discharged during the COVID19 Public Health Emergency (PHE) period.

DRG Reimbursement (IPPS)

https://www.cms.gov/files/document/se20015.pdf

Inpatient Prospective Payment System (IPPS) Hospitals –

Discharges of an individual diagnosed with COVID19 will be identified by the presence of the following International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes:

- **B97.29** (Other coronavirus as the cause of diseases classified elsewhere) for discharges occurring on or after January 27, 2020, and on or before March 31, 2020.
- **U07.1** (COVID-19) for discharges occurring on or after April 1, 2020, through the duration of the COVID-19 public health emergency period.

(Continued)

DRG Reimbursement (IPPS)

Inpatient Prospective Payment System (IPPS) Hospitals – *continued*

Providers may refer to the following ICD-10-CM coding guidance for coding encounters related to COVID-19:

- For discharges on or after April 1, 2020, the ICD-10-CM Official Coding and Reporting Guidelines are at https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf
- For discharges prior to April 1, 2020, the ICD-10-CM Official Coding Guideline – Supplement is at https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-CodingGudance-Interim-Advice-coronavirus-feb-20-2020.pdf

DRG Reimbursement (IPPS)

Inpatient Prospective Payment System (IPPS) Hospitals – *continued*

To implement this temporary adjustment, Medicare's claims processing systems will apply an adjustment factor to increase the Medicare Severity-Diagnosis Related Group (MS-DRG) relative weight that would otherwise be applied by 20 percent when determining IPPS operating payments for discharges described above.

IPPS – DRG weight of 0.8125

FY 2020 Inpatient Prospective Payment (IPPS) Payment Results

Calculator Version: C20.0

Claim Return Code: 14 - Paid normal DRG payment with perdiem days = or > GM ALOS.

PROVIDER DETAILS

Provider #: 500041	
PSF Record Eff Date:	10/01/2019
Provider Type:	17
GEO/STD CBSA:	31020 / 50
Reclass CBSA:	

CLAIM DETAILS

Patient Id:	
DRG:	204
Discharge Date:	03/17/2020
Length of Stay:	2 Days
Charges:	$40,000.00

PPS FACTORS & ADJUSTMENTS

OP/CAP CCR:	0.3010 / 0.0140
OP/CAP DSH:	0.2275 / 0.0000
Operating IME:	000000.000000000
Capital IME:	000000.000000000
Nat Labor/Non-Labor %:	0.6830 / 0.3170
Nat Labor:	03959.10
Nat Non-Labor:	01837.53
Inp Wage Index:	01.0101
Inp PR Wage Index:	00.0000
Inp DRG Weight:	00.8125
Inp DRG GM ALOS:	02.2
Transfer Adj. Factor:	0.0000
Readmissions Adj. Factor:	0.9878
VBP Adj. Factor:	0.99905670680
Bundle %:	0.000
EHR Reduction Indicator:	
HAC Reduction Indicator:	N
Cost Outlier Threshold:	$0.00

CAPITAL AMOUNTS

C-FSP:	$378.24
C-Outlier:	$0.00
C-DSH:	$0.00
C-IME:	$0.00

OPERATING AMOUNTS

O-FSP:	$4,742.25
O-HSP:	$0.00
O-Outlier:	$0.00
O-DSH:	$269.72
O-IME:	$0.00
Uncomp Care:	$684.78
Readmissions Adj.:	$57.86CR
VBP Adjustment:	$4.47CR
New Tech:	$0.00

OTHER PPS AMOUNTS

HAC Adj.:	$0.00
Low Volume:	$0.00
Pass Thru + Misc:	$0.00
Islet Add-on:	$0.00
EHR Adj.:	$0.00
Bundle Adj.:	$0.00
MA-HSP:	$0.00

*** TOTAL PAYMENT ***

$6,012.66

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With 20% Bump - weight of 0.9741

FY 2020 Inpatient Prospective Payment (IPPS) Payment Results

Calculator Version: C20.0

Claim Return Code: 00 - Paid normal DRG payment.

PROVIDER DETAILS

Provider #: 500041	
PSF Record Eff Date:	10/01/2019
Provider Type:	17
GEO/STD CBSA:	31020 / 50
Reclass CBSA:	

CLAIM DETAILS

Patient Id:	
DRG:	596
Discharge Date:	03/17/2020
Length of Stay:	2 Days
Charges:	$40,000.00

PPS FACTORS & ADJUSTMENTS

OP/CAP CCR:	0.3010 / 0.0140
OP/CAP DSH:	0.2275 / 0.0000
Operating IME:	000000.000000000
Capital IME:	000000.000000000
Nat Labor/Non-Labor %:	0.6830 / 0.3170
Nat Labor:	03959.10
Nat Non-Labor:	01837.53
Inp Wage Index:	01.0101
Inp PR Wage Index:	00.0000
Inp DRG Weight:	00.9741
Inp DRG GM ALOS:	03.4
Transfer Adj. Factor:	0.0000
Readmissions Adj. Factor:	0.9878
VBP Adj. Factor:	0.99905670680
Bundle %:	0.000
EHR Reduction Indicator:	
HAC Reduction Indicator:	N
Cost Outlier Threshold:	$0.00

CAPITAL AMOUNTS

C-FSP:	$453.46
C-Outlier:	$0.00
C-DSH:	$0.00
C-IME:	$0.00

OPERATING AMOUNTS

O-FSP:	$5,685.45
O-HSP:	$0.00
O-Outlier:	$0.00
O-DSH:	$323.36
O-IME:	$0.00
Uncomp Care:	$684.78
Readmissions Adj.:	$69.36CR
VBP Adjustment:	$5.36CR
New Tech:	$0.00

OTHER PPS AMOUNTS

HAC Adj.:	$0.00
Low Volume:	$0.00
Pass Thru + Misc:	$0.00
Islet Add-on:	$0.00
EHR Adj.:	$0.00
Bundle Adj.:	$0.00
MA-HSP:	$0.00

*** TOTAL PAYMENT ***

$7,072.33

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CMS Waivers – Slide Deck

- https://www.cms.gov/files/document/cms-waivers-and-covid-19-response.pdf

Two types of 1135 Waivers

Medicare Blanket Waivers

CMS implements specific waivers or modifications on a "blanket" basis when a determination has been made that all similarly situated providers in the emergency area need such a waiver or modification.

Once approved, these waivers apply automatically to all applicable providers and suppliers. Providers and suppliers do not need to apply for an individual waiver if a blanket waiver is issued by CMS.

Provider/Supplier Individual Waivers

Individual waivers can be issued for states, providers or suppliers. **These only need to be applied for if something is needed beyond what is provided under an existing blanket waiver.**

Two new areas in this emergency are:

1. COVID-19 facility setup, such as transfer from SNF, HH, etc. to another location (e.g. a hotel used as a temporary treatment facility)
2. Medical evaluation at drive-thru testing locations

COVID-19 & Financial Health

- LIMIT FINANCIAL FALLOUT
  - Extended suspension of higher-margin elective surgeries
  - Increased supply costs and supply chain disruptions
  - Rising labor costs due to extended operational demands
  - Payer disruptions affecting timely reimbursement

- OPERATIONAL CONSIDERATIONS
  - Use of new COVID-19 coding methodology to avoid denials and payment delays
  - Ensure timely claims submission and denial resolution
  - Monitor payer mix as increased government payer claims could have impact on budget projections
  - Use automated payer denial resolution processes to limit payer hold times for hospital staff
  - Enable receipt of 266/267 claim status files from clearinghouses for most up-to-date information about unpaid claims

COVID-19 & Financial Health

- WORKING REMOTE
  - Reduction of non-critical, on-site staff
  - Revenue cycle employees can continue to code, file claims, and manage AR from home
  - Requires robust work-at-home platforms
  - Encryption for both data at rest and data in flight
  - Multifactor authentication
  - Secure operating environments

- TRUSTED THIRD-PARTY ASSISTANCE
  - Consider partnering with a trusted third-party capable of taking over elements of the revenue cycle for the duration of the crisis
  - Partner should be able to scale up quickly to handle additional workflow and reduce disruptions to the revenue cycle

Questions

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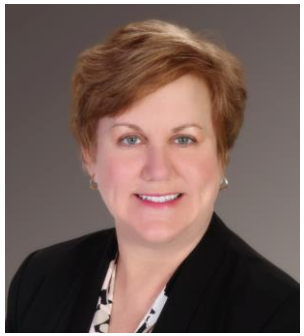
Contact Us



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