IHS Medicare COVID19 Billing Guidance – Version 1.0

April 27, 2020

*This document is intended to serve as **temporary** guidance for Indian Health service facilities and staff on various billing questions that are surfacing during the Public Health Emergency (PHE)/COVID-19 Pandemic. At this time, most of the regulatory waivers that have been put in place are temporary and are changing sometimes on a daily basis so it is anticipated that future updated versions of this guidance will be available. This particular guidance focuses primarily on Medicare billing for services during the PHE. For guidance on Medicaid billing, Private Insurance billing, etc, IHS facilities should reach out to their various payers to receive appropriate guidance. This guidance was developed by a team that researched, analyzed and interpreted numerous new regulations, waivers, and guidance. The team welcomes your suggestions for corrections, updates and different interpretations. This is Version 1.0. This document will be updated, amended, and added to as more information/guidance becomes available. This document is not intended as legal advice. If legal guidance is required, IHS facilities should seek assistance through proper channels from the Office of the General Counsel (OGC).*

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Topic	*Scenario*	*Description and Requirements*	*Billing Requirements*
Telemedicine			
Originating Sites: These billing requirements have not changed during this PHE.	Patient comes into the facility and the Provider/Patient are present in the same location at the time the service is furnished via a telecommunications system	If the beneficiary is in a healthcare facility and receives services via telehealth the health care facility would bill for the originating site facility fee FQHCs, RHCs, GF FQHCs can also bill as the Originating site.	**Codes:** Use Code Q3014 to bill the facility fee **Revenue Code**: 078X **Form:** UB/837I
Distant Sites:			
Enrollment for Telemedicine Sites	Provider/Facility is providing Telemedicine services at a remote (other than their enrolled location of service) location such as Home, other Office, other Expansion Site.	A facility **does NOT** have to enroll that location of service in the Medicare Program. A Physician/Non Physician **DOES** have to be enrolled in the Medicare Program.	For Rapid Enrollment, Providers can use the toll free hotline to access enrollment quickly. Toll Free Number: 1-855247-8428 Option 2
Facility Billing (Part A) for Telemedicine Services		Currently a Hospital and/or a Provider Based facility **CANNOT** bill a Facility bill (Part A) to Medicare for Telemedicine Services.	
Place of Service	*For Distant Site Telemedicine Service, use the Place of Service (POS) code that is equivalent to "where the face to face encounter" would have occurred. Think of the Type of Location*	19 - Off Campus-Outpatient Hospital 22 - On Campus-Outpatient Hospital 23 - Emergency Room/Hospital	

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		11-Office	
Removal of Frequency Limitations on Medicare Telehealth Services	Currently there are three situations in which the frequency limitations on Telehealth services has been waived.	Frequency Limitations no longer apply to: CPT codes 99231-99233: □ A subsequent inpatient visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every three days CPT codes 99307-99310: A subsequent skilled nursing facility visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every 30 days CPT codes G0508-G0509: Critical care consult codes may be furnished to a Medicare beneficiary by telehealth beyond the once per day limitation.	
Types of Telemedicine	***Currently, there are four TYPES of Telemedicine Visits:*** *Telehealth Visits* *Virtual Check In* *E-Visits* *Telephone E/M Visits*	**Patients approval** to participate in virtual telemedicine visits can be a verbal consent, at least on a yearly basis.	Always bill Distant Telemedicine Visits to **Medicare Part B** on a **CMS1500/837P**.

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			Modifiers: CR modifier and the **DR** condition code are NOT required on telehealth services
Telehealth Visits: Medicare telehealth services are services that would **normally occur in person** but are instead conducted via telecommunications technology and are **paid at the full inperson rate** (Part B rate)	Patient is at home or any other location and contacts (or is contacted by) an eligible Medicare provider via real time synchronous communications. Medicare Provider provides the proper E/M services via Audio and Video communications.	Patient and Provider can be at any location. Provider is acting as the Distant Site. Must be Audio and Video, real time communication. Can be initiated by the Provider. Now applies to both New and Established Patients Health professionals can bill for **telehealth** services: Physicians Nurse practitioners (NPs) Physician assistants (PAs) Clinical nurse-midwives (CNMs) Clinical nurse specialist (CNSs) Certified registered nurse anesthetists (CRNAs) Clinical psychologists (CPs)	**Codes –** Use the E/M Codes that are specific to the location 99201 – 99215 (Office and outpatient visits) G0425 – G0427 (Telehealth consultations, emergency department or initial inpatient) G0406 – G0408 (Follow up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) 99281 – 99285 (Emergency Department Visits) 99217 – 99220; 99224 – 99226; 99234 – 99236 (Initial and Subsequent Observation and Observation Discharge Day Management) 99221 – 99223; 99238 – 99239 (Initial hospital care and hospital discharge day management 96130 – 96133; 96136 – 96139 (Psychological and Neuropsychological Testing)

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		Clinical social workers (CSWs) Registered dietitians (RDs) Nutrition professionals	**POS** – equal to what it would have been had the service been furnished in person **Modifier – 95 -** indicating that the service rendered was actually performed via telehealth: □ **Additional User of Modifiers:** Modifier **GQ** – Used when telehealth services are furnished via asynchronous (store and forward) technology as part of a federal telemedicine demonstration project in Alaska and Hawaii Modifier **G0** – Used for the diagnosis and treatment of an acute stroke Modifier **GT** - CAH method II claims **Form** = CMS1500/837P
Virtual Check In Medicare pays for these ″virtual check-ins″ (or Brief	Assess the patient to determine if they need to be seen. A brief (5 – 10 minutes) check-in with the patient's practitioner via telephone or other	Patient can be at any location. Provider is acting as the Distant Site.	**Codes:** G2012 Telephone Only G2010 – Image or Video sent in by patient

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communication technology-based service) for patients to communicate with their doctors and avoid unnecessary trips to the doctor's office. Service such as the virtual check-in, remote evaluation, and telephone visits are **not services that would normally occur in person**, and are not paid as though the service occurred in person.	telecommunications device to decide whether an office or other service is needed, OR A remote evaluation of recorded video and/or images are submitted by patient Patient calls physician/non practitioner and they fell and hurt their arm and they talked the physician/non practitioner, they told her to take Tylenol and if get worse to come in, as long as it is not within 24 hours or first available appointment. OR A remote evaluation of recorded video and/or images are submitted by patient to physician/non practitioner for evaluation that they have a "rash" and the patient has not been to the " physician/non practitioner" in the past 7 days and that this "issue" does not require a visit within the next 24 hours or next available appointment, maybe the rash is from something they	Must be initiated by the patient. Can be synchronous (real time), or asynchronous (store and forward). Now applies to both New and Established Patients. In addition to the list of providers that provide Telehealth services: PTs, OTs and SLPs can bill for the following Virtual Check In Services:	**POS: Place of service where services are provided from** **Form:** CMS1500/837P **Modifier: No Modifier.** Not a TELEHEALTH Visit, since no E/M services were provided.

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	ate/lotion and the physician/non practitioner tells them to watch it, no visit necessary. .		
E-Visits An online patient portal is a secure online website that gives patients 24-hour access to personal health information from anywhere with an Internet connection by using a secure username and password.	Patient initiates communication with Medicare Provider via an established Medical Services Patient Portal. Communications can occur over a 7-day period Time is based on cumulative time in a 7 day period. Cumulative means that the provider tracks the time and efforts that they spend assessing or evaluating the Patients entry in the portal over a 7 day period.	Via Portal Patient can be at any location. Provider is acting as the Distant Site. Non-face to face communication via ONLINE PATIENT PORTAL. Patient must initiate the communication. Now applies to both New and Established Patients. In addition to the list of providers for Telehealth: Practitioners (physicians/NPs) who may independently bill Medicare for E&M visits can bill the following codes: 99421-99423	**Codes:** CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable. **POS: Place of service where service was provided from** **Modifier: No Modifier** **Form: CMS1500/837P**

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		Clinicians (physical therapists, occupational therapists, speech language pathologists, and licensed CPs and CSWs) who may not independently bill for E&M can perform these e-visits and bill: G2061-G2063	
Telephone E/M service provided by a physician to an established *patient, parent, or guardian.* report telephone E&M for beneficiaries who need routine, uncomplicated follow-up for chronic disease or routine primary care for non-face-to-face patient-initiated communications with their doctor using a telephone,	In a case where two-way audio and video technology required to furnish a Medicare telehealth service might not be available, there are circumstances where prolonged, audio-only communication between the practitioner and the patient could be clinically appropriate yet not fully replace a face-to-face visit. For the duration of the PHE for the COVID-19 pandemic, Medicare will make separate payment for audio-only Evaluation and Management Visit.	In addition to the list of providers that provide Telehealth services: PTs, OTs and SLPs can bill for Telephone assessment (only) services Reported for new and established patient	**Codes:** Non Physician telephone *assessment* and management services: 98966 – 5-10 min 98967 – 11-20 min 98968 – 21-30 min Physician telephone *evaluation* and management services: 99441 – 5-10 min 99442 – 11-20 min 99443 – 21-30 min **POS: Place of Service where services are provided from.** **Modifier: No Modifier** **Form: CMS1500/837P**

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Remote Patient Monitoring	Clinicians can provide remote patient monitoring. For example, remote patient monitoring can be used to monitor a patient's oxygen saturation levels using pulse oximetry.	Can apply to new and established patients. Can be provided for both acute and chronic conditions. Can now be provided for patients with only one disease.	Codes: 99091(Remote patient monitoring) 99457-99458 (Chronic care remote patient monitoring) 99473- 99474 (Blood pressure self-measurement) 99493-99494 (Psychiatric collaborative care management) **POS: Place of Service where services are provided from.** **Modifier: No Modifier** **Form: CMS1500/837P**
Miscellaneous Guidance:			
Cost Sharing Modifier: CS	The Families First Coronavirus Response Act waives cost-sharing under **Medicare Part B** (coinsurance and deductible amounts) for Medicare patients for **COVID-19 testing-related services.** These services are medical visits for the HCPCS **evaluation and management categories** described below when an outpatient provider, physician, or other providers and suppliers	use the CS modifier on applicable claim lines to identify the service as subject to the cost-sharing wavier for COVID-19 testing related services and to get 100% of the Medicare-approved amount. Applies to Medicare Part B E/M Services billed.	Effective for DOS = March 18, 2020 Codes: Appropriate E/M Code POS: Place of Service where services are provided from Modifier: CS Form: CMS1500/837P ***At this time, the CS modifier does not apply to the Facility Bill (Part A) whereas the E/M service resulted in the ordering,***

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	that bill Medicare for Part B services orders or administers COVID-19 lab test U0001, U0002, or 87635. Patient presents or patients received a Telemedicine service that results in an order of, or actual COVID19 test being performed.	Only applies to those Telemedicine services where a E/M code are provided (Telehealth Visit)	***or actual giving the COVID19 Lab Tests.*** ***Per Novitas 04/22/2020*** We have received clarification from CMS, IHS UB-04 (Part A Facility) claims will not use the "CS" modifier for cost sharing.
Claims Submitted Incorrectly during PHE.	Submitted claims with DOS during PHE: Without 95 modifier With Wrong POS (used 02 incorrectly) Without CS Modifier		Resend any claims to your appropriate MAC that were not billed per these new guidelines.
Part B 2% Sequestration Adjustment	Currently, Medicare applies a 2% reduction in payment for all Part B FFS payments for Sequestration.	CMS will suspend this Assessment on all claims with DOS May 1, 2020 through December 31, 2020	No billing changes. Watch your Medicare Part B to ensure you are not assessed the 2% reduction for DOS as of May 1, 2020.
CMS Hospital Without Walls: Physical Location of Service:	From a **facility** perspective: Do we have to enroll these temporary facilities in Medicare? Do we need a new facility	If "temporary" facility is repurposed, or expanded to an outside location, the facility DOES NOT have to enroll, or	

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We are setting up "temporary" facilities (clinics), under the same Governing Board as the Parent Hospital/Provider based Clinics, or Freestanding Clinics: CMS will now temporarily permit non-hospital buildings and spaces to be used for patient care and quarantine sites, provided that the location is approved by the State and ensures the safety and comfort of patients and staff.	number? Or do we need to add these temporary addresses to any Facility Medicare Enrollment form (CMS-855A)? From a **Physician** perspective: If we have Medicare Part B Providers (already enrolled) now providing Part B services at these temporary locations will we have to redo all 855Bs to include these locations and redo all CMS-855Is to reflect this?	include the Physical Address on the enrollment application. If a "New permanent" facility is established, the facility will have to enroll to get a new Medicare Number. If the "New permanent" facility is a provider based facility, established under an existing Hospital location (CCN) the facility address will have to be added to the Hospitals Enrollment forms. Physician/Non-Physician Medicare Providers HAVE TO ENROLL, regardless of the location of service.	
Blanket Waiver Condition Codes and Modifiers = DR and CR	**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	**Do not use these modifiers for Telehealth.** Also, **practitioners** should add the modifier "**CR"** to professional claims for patients treated in **temporary**	IHS is seeking more clarification from CMS and will address in version 2.0.

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	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 pharmacies, in the NCPDP format). **Questions for CMS:** **Do we use these modifiers ONLY when the services are provided in a temporary expansion site (waiver)?** **Are there other scenarios that we must use these modifiers?**	**expansion site** during the Public Health Emergency. **Hospitals** should add the "**DR"** condition code to inpatient and outpatient claims for patients treated in **temporary expansion site** during the Public Health Emergency.	

New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE) – MLN SE20016 – April 17, 2020

Distant Site	Prior to COVID-19 PHE	Billing Requirements	During COVID-19 PHE	Billing Requirements
A distant site is where the health care provider is located.	RHCs and FQHCs are not authorized to serve as distant site for telehealth consultations, and may not bill or include the cost of a visit on the cost report. This includes telehealth services that are furnished by an FQHC practitioner who is employed by or under contract with the FQHC, or a non-FQHC practitioner furnishing services through a direct or indirect contract. Eligible distant site practitioners are as follows: • Physicians • Nurse practitioners	Not applicable.	MLN: SE20016 – April 17, 2020 RHCs and FQHCs can immediately provide and be paid for any **telehealth** service that is **approved** as a distant site service under the Physician Fee Schedule to Medicare patients during the duration of the COVID-19 PHE. Review list of Approved Telehealth services under PHE. Furnished by any health care practitioner working for the RHC or FQHC within their scope of practice. Medicare telehealth services require an interactive audio and video telecommunication system that permits real-time communication between the practitioner and the patient.	Distant site services furnished between January 27, 2020 and June 30, 2020: FQHCs FQHC G-code Revenue Code 0521 Modifier: 95 RHCs Telehealth code Revenue code 0521 or 0780 Modifier 95 Sites will be reimbursed at their AIR or PPS. Claims will be automatically reprocessed in July for the new rate. Do not resubmit these claims for the payment adjustment.

Distant Site	Prior to COVID-19 PHE	Billing Requirements	During COVID-19 PHE	Billing Requirements
	• Physician assistants • Nurse-midwives • Clinical nurse specialists • Certified registered nurse anesthetists • Clinical psychologists and clinical social workers • Registered dieticians or nutritional professionals • Opioid Treatment Programs		Practitioners can furnish distant site telehealth services from any location, including their home, during the time that they are working for the RHC or FQHC. Payment to RHCs and FQHCs for distant site telehealth services is set at $92, which is the average amount for PFS telehealth services on the telehealth list, weighted by volume for those services report under the PFS. The Medicare Advantage (MA) wrap-around payment does not apply to these services. Wrap-around payment for distant site telehealth services will be adjusted by the MA plans. <u>Cost Report</u> Cost for furnishing telehealth will not be used to determine the RHC AIR or FQHC PPS rate RHC must report originating and distant telehealth costs on	Distant sites services furnished between July 1, 2020 and the end of the COVID-19 PHE: <u>FQHCs</u> Code: G2025 Revenue Code 0521 or 0780 No G-code or 95 modifier <u>RHCs</u> Code: G2025 with no modifiers Continue to report CG modifier required under the AIR (SG95) Revenue Code 0521 or 0780 G2025 will be paid at the $92.00 rate.

Distant Site	Prior to COVID-19 PHE	Billing Requirements	During COVID-19 PHE	Billing Requirements
			FORM CMS-222-17 on line 79 of Worksheet A, in section titled "Cost Other Than RHC Services" FQHC must report originating and distant site telehealth costs on Form CMS-224-14, The Federally Qualified Health Center Cost Report, on line 66 of Worksheet A, in the section "Other FQHC Services".	Using CS Modifier When Cost-Sharing is Waived Append CS modifier to services related to COVID-19 testing, including applicable telehealth services. Do not charge the beneficiary coinsurance and/or deductible Do not append CS modifier on the COVID-19 lab test. Labs are not an RHC or FQHC service. Lab services are billed to the Part B MAC, if applicable. MACs will automatically reprocess these claims beginning on July 1.

Originating Site	Prior to COVID-19 PHE	Billing Requirements	During COVID-19 PHE	Billing Requirements
An originating site is the location of an eligible Medicare beneficiary at the time of the service.	RHCs and FQHCs are authorized to be originating telehealth sites. Telehealth services are paid an originating site facility fee. Originating site fee can be billed when the patient is in an FQHC located in a rural (non-MSA) area or rural health professional shortage area, in order to receive a telehealth consultation service from a practitioner at a distant location.	Revenue Code 0780 HCPCS Q3014 Payment rate 26.65 Beneficiary is responsible for any unmet deductible and coinsurance.	No changes. Patient does have to be at the RHC or FQHC in order to bill the originating site fee.	No changes.

Virtual Check-in or Communication Services	Prior to COVID-19 PHE	Billing Requirements	During COVID-19 PHE	Billing Requirements
	Patient initiated At least 5 minutes of communication technology-based evaluation services furnished by a practitioner to the patient who has had a billable visit within the previous year and both are met: The medical discussion or remote evaluation is for a condition not related to a billable visit within the previous 7 days, and The medical discussion or remote evaluation does not lead to an RHC/FQHC visit with the next 24 hours or at the soonest appointment.	For DOS on/after January 1, 2019: HCPCS code G0071, billed alone or with other payable service Revenue Code: 0521 Payment rate $13.69 Payment for G0071 is set at the average national non-facility PFS payment rates for HCPCS G2012 (communication technology-based services and HCPCS code G2010 (remote evaluation services) Coinsurance applies	Expansion of Virtual Communication Services to include online digital E&M services using patient portals. Online digital E&M services are non-face-to-face patient-initiated, digital communications using a secure patient portal. Online digital E&M Codes that are billable during the COVID-19 are: 99421 – Online digital E&M, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes 99422 – Online digital E&M, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes 99423 – Online digital E&M, for an established patient, for up to 7 days, cumulative time	HCPCS code G0071, billed alone or with other payable service Revenue Code: 0521 Payment rate $24.76 Cannot be billed more than once every 7 days.

Virtual Check-in or Communication Services	Prior to COVID-19 PHE	Billing Requirements	During COVID-19 PHE	Billing Requirements
	Face-to-Face requirements are waived. Beneficiary consent is required for all services, including non-face-to-face services.		during the 7 days; 21 or more minutes Under PHE, can be furnished to both new and established patients. Payment for G0071 is set at the average national non-facility PFS payment rates for HCPCS G2012 (communication technology-based services and HCPCS code G2010 (remote evaluation services) and 99421, 99422, and 99423. Beneficiary Consent should be obtained. During PHE, may be obtained at the same time the services are furnished. May be obtained by auxiliary personnel under general supervision such as an employee, independent contractor, or leased employee of the RHC/FQHC.	