Coding for COVID-19 and Non-Direct Care

Coding Guidance: ICD-10-CM

The introduction of SARS-CoV-2/2019-nCoV (COVID-19) in the United States has produced an influx of patients into the health care system. While knowing how to diagnose and treat these patients is vital, being able to appropriately capture this information for data tracking and payment also is important. The National Center for Healthcare Statistics has developed a resource for International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) coding that already is in effect.

COVID-19 attacks the respiratory system; therefore, suspicion of the disease typically will accompany respiratory conditions. A confirmation of COVID-19 will therefore be linked to a specific respiratory condition.

A new code is being introduced for use on or after April 1, 2020.

U07.1 COVID-19
Use this code as primary and also report manifestations such as pneumonia or bronchitis (see above). Note that you may not report codes B34.2, B97.2- or J12.81 in addition to the U07.1

The WHO also released another code that has not been approved for use in the US at this time (U07.2) therefore do not report until directed by the National Center for Healthcare Statistics.

- **Positive COVID:** Code only a confirmed diagnosis of the 2019 novel coronavirus disease (COVID-19) as documented by the provider, documentation of a positive COVID-19 test result, or a presumptive positive COVID-19 test result. For a confirmed diagnosis, assign code U07.1, COVID-19. “Confirmation” does not require documentation of the type of test performed; the provider’s documentation that the individual has COVID-19 is sufficient.

- **“Suspected” COVID:** If the provider documents "suspected," "possible," "probable," or "inconclusive" COVID-19, do not assign code U07.1. Assign a code(s) explaining the reason for encounter (such as fever) and/or Z20.828, Contact with and (suspected) exposure to other viral communicable diseases.

- **Pneumonia/+COVID:** For a pneumonia case confirmed as due to the 2019 novel coronavirus (COVID-19), assign codes U07.1 and J12.89, Other viral pneumonia.

- **Acute bronchitis/+ COVID:** For a patient with acute bronchitis confirmed as due to COVID-19, assign codes U07.1 and J20.8, Acute bronchitis due to other specified organisms. If the bronchitis is not specified as acute, due to COVID-19, report code U07.1 and J40, Bronchitis, not specified as acute or chronic.

- **Lower respiratory infection/+COVID:** If the COVID-19 is documented as being associated with a lower respiratory infection, not otherwise specified (NOS), or an acute respiratory infection, NOS, report with codes U07.1 and J22, Unspecified acute lower respiratory infection. If the COVID-19 is documented as being associated with a respiratory infection, NOS, it would be appropriate to assign codes U07.1 and J98.8, Other specified respiratory
disorders.

- **Acute respiratory distress syndrome (ARDS)/COVID:** ARDS may develop in conjunction with COVID-19. Cases with ARDS due to COVID-19 should be assigned the codes **U07.1** and **J80**, Acute respiratory distress syndrome.

- **Exposure to COVID:** For cases where there is a concern about a possible exposure to COVID-19, but this is ruled out after evaluation, assign code **Z03.818**, Encounter for observation for suspected exposure to other biological agents ruled out. For cases where there is 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, assign code **Z20.828**, Contact with and (suspected) exposure to other viral communicable diseases.

- **Signs and symptoms:** For patients presenting with any signs/symptoms associated with COVID-19 (such as fever, etc.) but a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms such as:
  - **R05** Cough
  - **R06.02** Shortness of breath
  - **R50.9** Fever, unspecified
  
  If a patient with signs/symptoms associated with COVID-19 also has an actual or suspected contact with someone who has COVID-19, assign code **Z20.828**.

- **Screening for COVID:** For asymptomatic individuals who are being screened for COVID-19 and have no known exposure to the virus, and the test results are either unknown or negative, assign code **Z11.59**, Encounter for screening for other viral diseases. For individuals who are being screened due to a possible or actual exposure to COVID-19, see guideline for Exposure. For asymptomatic individuals who test positive for COVID-19, assign code **U07.1**.

- **Pneumonia:** For a pneumonia case confirmed as due to the 2019 novel coronavirus (COVID-19), assign codes **J12.89**, Other viral pneumonia, and **B97.29**, Other coronavirus as the cause of diseases classified elsewhere.

- **Acute bronchitis:** For a patient with acute bronchitis confirmed as due to COVID-19, assign codes **J20.8**, Acute bronchitis due to other specified organisms, and **B97.29**. If the bronchitis is not specified as acute, due to COVID-19, report code **J40**, Bronchitis, not specified as acute or chronic, along with code **B97.29**.

- **Lower respiratory infection:** If the COVID-19 is documented as being associated with a lower respiratory infection, not otherwise specified (NOS), or an acute respiratory infection, NOS, report with code **J22**, Unspecified acute lower respiratory infection, with code **B97.29**. If the COVID-19 is documented as being associated with a respiratory infection, NOS, it would be appropriate to assign code **J98.8**, Other specified respiratory disorders, with code **B97.29**.

- **Acute respiratory distress syndrome (ARDS):** ARDS may develop in conjunction with COVID-19. Cases with ARDS due to COVID-19 should be assigned the codes **J80**, Acute respiratory distress syndrome, and **B97.29**.

- **Exposure to COVID-19:** For cases where there is possible exposure to COVID-19, but the disease is ruled out, report code **Z03.818**, Encounter for observation for suspected exposure to other biological agents ruled out. For cases where there is an actual exposure to someone who is confirmed to have COVID-19, report code **Z20.828**, Contact with and (suspected) exposure to other viral communicable diseases. This code is not necessary if the exposed patient is confirmed to have COVID-19.

- **Signs and symptoms:** For patients presenting with any signs/symptoms and where a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms such as: Cough (**R05**); Shortness of breath (**R06.02**) or Fever unspecified (**R50.9**).
Coding Guidance: CPT and HCPCS

There are no unique codes for evaluating and managing COVID-19; however, be sure to clearly document any additional time spent with the family or time spent coordinating any care that is not face-to-face with the patient and/or family.

Testing

There is no code for swabbing the patient for COVID-19, much like there is no code for swabbing for influenza. However, if the specimen will be prepared by your office and sent to an outside lab, report the specimen collection code 99000.

The Centers for Medicare & Medicaid Services (CMS) developed two new lab testing codes:

- U0001 will be reported for coronavirus testing using the Centers for Disease Control and Prevention (CDC) 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel.
- U0002 will be reported for validated non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19).

If your office is not running the test for COVID-19 or incurring the cost, you will not report these codes.

The American Medical Association Current Procedural Terminology (CPT) Editorial Panel developed a CPT code which streamlines novel coronavirus testing offered by hospitals, health systems, and laboratories in the United States. The code was effective March 13, 2020, for use as the industry standard for reporting of novel coronavirus tests across the nation's health care system.

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

The following codes, guidelines, and parenthetical notes were accepted and/or revised at the April 2020 CPT Editorial Panel meeting for the 2021 CPT production cycle. The codes, guidelines, and parenthetical notes are effective immediately on April 10, 2020.

86328 Immunoassay for infectious agent antibody(ies), qualitative or semi quantitative, single step method (eg, reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])

(For severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [Coronavirus disease [COVID-19]] antibody testing using multiple step method, use 86769)

86769 Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])

Telemedicine and Telehealth

As concerns arise over the easy spread of COVID-19, there has been increasing use of telemedicine and telehealth.

Telemedicine is very specific and only applies to codes typically performed in-person but rendered via a real-time (synchronous) interactive audio and video telecommunications system. Telemedicine requires use of modifier 95 and is limited to codes listed in Appendix P of the CPT manual (eg, 99213-95). Telemedicine is only one type of telehealth.

Telehealth refers broadly to electronic and telecommunications technologies and services used to provide care and services at-a-distance. Therefore, it includes services such as telephone care and eVisits.

Please note that CMS and other payers may use the terms interchangeably.

Knowing your state laws and payer rules is important. (Please see ‘Resources’ section below for AAP Telemedicine Coding Fact Sheet and help in navigating your state laws on telehealth services). If a payer wants you to report a code outside of its intention, make sure to get it in WRITING!
**Medicare COVID-19 Telehealth Expansion**

On March 17, 2020, the Trump Administration announced expanded Medicare telehealth coverage that will enable beneficiaries to receive a wider range of health care services from their doctors without having to travel to a health care facility. Beginning on March 6, 2020, Medicare will temporarily pay clinicians to provide telehealth services for beneficiaries residing across the entire country (see resources). Prior to this announcement, Medicare was only allowed to pay clinicians for telehealth services such as routine visits in certain circumstances. For example, the beneficiary receiving the services must live in a rural area and travel to a local medical facility to get telehealth services from a doctor in a remote location. In addition, the beneficiary would generally not be allowed to receive telehealth services in their home. A range of health care providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to Medicare beneficiaries. Beneficiaries will be able to receive telehealth services in any health care facility including a physician’s office, hospital, nursing home or rural health clinic, as well as from their homes. Medicare beneficiaries will be able to receive various services through telehealth including common office visits, mental health counseling, and preventive health screenings. This will help ensure Medicare beneficiaries, who are at a higher risk for COVID-19, are able to visit with their doctor from their home. As part of this announcement, patients will now be able to access their doctors using a wider range of communication tools including telephones that have audio and video capabilities, making it easier for beneficiaries and doctors to connect. Clinicians can bill immediately for dates of service starting March 6, 2020. Telehealth services are paid under the Medicare Physician Fee Schedule at the same amount as in-person services. Medicare coinsurance and deductible still apply for these services.

Additionally, the HHS Office of Inspector General (OIG) is providing flexibility for health care providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

Cost-sharing does not apply for COVID-19 testing-related services, which are medical visits that: are furnished between March 18, 2020 and the end of the Public Health Emergency (PHE); that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test; and are in any of the following categories of HCPCS evaluation and management codes:

- 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

Cost-sharing does not apply to the above medical visit services for which payment is made to:

- Hospital Outpatient Departments paid under the Outpatient Prospective Payment System
- Physicians and other professionals under the Physician Fee Schedule
- Critical Access Hospitals (CAHs)
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)

For services furnished on March 18, 2020, and through the end of the PHE, outpatient providers, physicians, and other providers and suppliers that bill Medicare for Part B services under these payment systems should use the CS modifier on applicable claim lines to identify the service as subject to the cost-sharing waiver for COVID-19 testing-related services and should NOT charge Medicare patients any co-insurance and/or deductible amounts for those services.

*Update 4/11/20*

In March 2020, representatives of major health insurance companies met with President Trump, where they voluntarily committed to covering COVID-19 testing without cost sharing such as copays and coinsurance. Building on this commitment, this guidance implements the recently enacted Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security (CARES) Act, which require that private health issuers and employer group
health plans cover COVID-19 testing and certain related items and services furnished during the COVID-19 pandemic, with no out-of-pocket expenses.

Specifically, this announcement implements the requirement for group health plans and group and individual health insurance to cover both diagnostic testing and certain related items and services provided during a medical visit with no cost sharing. This includes urgent care visits, emergency room visits, and in-person or telehealth visits to the doctor’s office that result in an order for or administration of a COVID-19 test.

Covered COVID-19 tests include all FDA-authorized COVID-19 diagnostic tests, COVID-19 diagnostic tests that developers request authorization for on an emergency basis, and COVID-19 diagnostic tests developed in and authorized by states. It also ensures that COVID-19 antibody testing will also be covered. Once broadly available, a COVID-19 antibody test could become a key element in fighting the pandemic by providing a more accurate measure of how many people have been infected and potentially enabling Americans to get back to work more quickly.

Medicaid already provides a great deal of flexibility to states that wish to use telehealth services in their programs. States can cover telehealth using various methods of communication such as telephonic, video technology commonly available on smart phones and other devices. No federal approval is needed for Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for in-person services.

This guidance follows on President Trump's call for all insurance companies to expand and clarify their policies around telehealth.

**OCR COVID-19 HIPPA Enforcement Discretion**

In light of the COVID-19 nationwide public health emergency, the HHS Office for Civil Rights (OCR) is exercising its enforcement discretion and, effective immediately, will not impose penalties on physicians using telehealth in the event of noncompliance with the regulatory requirements under the Health Insurance Portability and Accountability Act (HIPAA).

Physicians may seek to communicate with patients and provide telehealth services through remote communications technologies. Some of these technologies, and their use, may not fully comply with the requirements of the HIPAA Rules (see resources).

However, today's announcement means that physicians who want to use audio or video communication technology to provide telehealth to patients during the COVID-19 nationwide public health emergency can use any non-public facing service that is available to communicate with patients. This exercise of discretion applies to telehealth provided for any reason, regardless of whether the telehealth service is related to the diagnosis and treatment of health conditions related to COVID-19.

For example, a physician using their professional judgement may request to examine a patient exhibiting COVID-19 symptoms, using a video chat application connecting the physician’s or patient’s phone or desktop computer in order to assess a greater number of patients while limiting the risk of infection of other persons who would be exposed from an in-person consultation. Likewise, a physician may provide similar telehealth services in the exercise of their professional judgment to assess or treat any other medical condition, even if not related to COVID-19, such as a sprained ankle, dental consultation or psychological evaluation, or other conditions.

Under this Notice, physicians may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype to provide telehealth without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules. Physicians should not use Facebook Live, Twitch, TikTok or other public facing communication services. Physicians are encouraged, but not required, to notify patients of the potential security risks of using these services and to seek additional privacy protections by entering into HIPAA business associate agreements (BAA). HHS also noted that while it hasn't confirmed such statements, Skype for Business, Updox, VSee, Zoom for Healthcare, Doxy.me, and Google G Suite Hangouts have said that their products will help physicians comply with HIPAA and that they will enter into a HIPAA BAA.
**Other Non-Direct Evaluation Services**

In the wake of the PHE, pediatric practices are looking for alternatives to risking unnecessary exposure via in-person visits. Some alternative services being offered are listed here with their codes. Be sure to look into these services more carefully. Refer to your CPT resources or visit the AAP resource.

**Digital Online Evaluation and Management**

For physicians and advanced practitioners (NP or PA)

99421 Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes

99422 11-20 minutes

99423 21 or more minutes

The following codes are reported by nonphysician providers who may independently bill such as physical therapists and psychologists, but are not reported for clinical staff (eg, RN) unless noted in writing by your payer.

98970 Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes

98971 11-20 minutes

98972 21 or more minutes

**Telephone Care**

For physicians and advanced practitioners (NP or PA)

99441 Telephone evaluation and management to patient, parent or guardian not originating from a related E/M service within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

99442 11-20 minutes of medical discussion

99443 21-30 minutes of medical discussion

The following codes are reported by nonphysician providers who may independently bill such as physical therapists and psychologists, but are not reported for clinical staff (eg, RN) unless noted in writing by your payer.

98966 Telephone assessment and management service provided by a qualified nonphysician healthcare professional to an established patient, parent or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

98967 11-20 minutes of medical discussion

98968 21-20 minutes of medical discussion

**Special Modifier**

CR Catastrophe/Disaster-Related

This modifier is currently being used for Medicare payment and tracking; therefore, consider reporting it with any service during this PHE. It should be reported as a secondary modifier to payment modifiers (eg, 25).
**Advocacy and Payment**

The AAP is monitoring health plan carrier uptake of the new Healthcare Common Procedure Coding System (HCPCS) Level II codes: **U0001** and **U0002**. Per CMS, the Medicare claims processing system will be able to accept this code for payment as of April 1 for dates of service on or after Feb. 4, 2020.

The Academy sent inquiries to the largest national carriers (Aetna, Anthem, Cigna, Humana and UnitedHealthcare) to ascertain their coverage policies. The carriers will offer the test with no patient out-of-pocket expense, and as of press time, Humana replied that it will follow CMS with retroactive coverage to Feb. 4, 2020. Carriers are waiting for CMS to value COVID-19 testing before establishing their fee schedules for the test. In the interim, providers should check their carrier contract regarding payments for services not included in the fee schedule (e.g., payment as a percentage of billed charges).

Additionally, several carriers are waiving co-payments for all diagnostic testing related to COVID-19 and for video visits (in lieu of office visits) for synchronous virtual care (live videoconferencing only).

**Resources**

- ICD-10-CM Resource
- CMS (Medicare) Resource
- Medicare Telemedicine Health Care Provider Fact Sheet
- Notification of Enforcement Discretion for Telehealth
- AAP Telemedicine Coding Fact Sheet
- AMA Quick Guide to Telemedicine in Practice
- Telehealth State Laws
- Non-Direct Care Coding Fact Sheet
- Additional AAP News Coverage of COVID-19
- Additional Coding Corner Columns

**FAQs**

**April 13, 2020**

Q. Can we report **preventive medicine services** (eg, 99393) via telemedicine (ie, real-time synchronous audio/visual service)?

A. At this time, neither CPT nor CMS have made an allowance to add preventive medicine service codes to their approved telemedicine visit lists. The AAP has made inquiries to allow their inclusion. No responses have been received to-date, but we will continue to keep you updated via this document.

We have discovered that some payers are allowing preventive medicine services to be provided via telemedicine; therefore, it may be worthwhile to check with your payers now.

Q. We “see” patients for telemedicine services after our usual office hours and on Saturdays. Is it appropriate to additionally report a **special service codes** 99050 (Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service) or 99051 (Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service Special Services – can you add 99050/99051) with the telemedicine service?

A. CPT has not yet addressed this issue. While the special services code descriptors do state “in the office,” payers may start to allow their use during this unprecedented time. The AAP does not believe that given the current environment...
their use is entirely inappropriate. However, please check with your payers since it is not entirely consistent with the current CPT code descriptors.

Q. We are implementing telemedicine. The physician is using a HIPAA-compliant platform to communicate with our patients who are usually at home. The physician is sometimes at home when these services take place. Can you please clarify what the place of service (POS) code should be reported?

A. Before the COVID-19 public health emergency (PHE) declaration, all telemedicine services were reported with POS code 02. And some payers are continuing to follow that guidance.

However, in the CMS Interim Final Rule With Comment Period (IFC), CMS has waived that requirement to allow physicians to report the POS code that would have been reported had the service been furnished in person (eg, POS 11 for office). This allows for Medicare payment at the same rate as would have been paid if the services were furnished in person. Service reported with POS 02 are paid assuming lower practice expense (PE), such as at the Facility rate. Facility rates are lower than Non-Facility rates due to the fact that there are fewer PE resources (ie, clinical staff time, medical supplies, medical equipment) expended by the physician in provision of the service.

Q. We see a patient via telemedicine. The patient comes to the office later that same day to be swabbed so that a strep test can be run. How do we handle coding for this, including the POS?

A. Please see answer above. Pre-PHE, the POS would have been 02 for the telemedicine service. And some payers are continuing to follow that guidance. However, CMS guidance is that during the COVID-19 PHE, the POS will be 11 (office) for the telemedicine service. The strep service will also be reported with POS 11 (office).

Q. We are using our digital online portal to communicate with patients. When the physician starts a communication with a patient about an issue (such as an ongoing chronic issue) and it meets the requirements for reporting a digital online E/M service (eg, 99442) what are the constraints? Meaning if we end up seeing the patient, can we report both the online and the office-based E/M services?

A. It depends. The digital online E/M service is a “7-day cumulative service.” Determine the day the digital online E/M service begins, which is the date of the initial communication from the patient. Let’s say the initial communication begins on March 10 and there is digital online communication through March 13, when the condition is “resolved.” If you end up seeing the patient in your office for a related condition after March 13, but on or before March 17 (ie, 7 days after the initial date of service of March 10), you cannot separately report the digital online E/M service. It would all be “bundled” into the office visit code (even if provided via telemedicine).

If, however, the patient experiences a flare up on March 22 and you see her, you may report both the digital online E/M service (making sure dates of service line up with when the service took place) and the office visit (eg, 99213) – even if provided via telemedicine.

Q. We are now moving away from using nebulizers in the office to using metered dose inhalers to administer medication. What codes are reported for the administration, supplies and if we have to teach the patient how to use at home?
A. The administration code will not change from the nebulizer and neither will the teaching service.

**Administration of the MDI**

94640 Pressurized or nonpressurized inhalation treatment for acute airway obstruction for therapeutic purposes and/or for diagnostic purposes such as sputum induction with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device

**Teaching/Demonstration for Home Use**

94664 Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device

If reporting both the 94640 and 94664, append modifier 25 to the E/M service (e.g., 99214) and modifier 59 to the 94664.

**Medication**

J3535 Drug administered through a metered dose inhaler

Report appropriate NDC code

Unit of measure is GR (Gram)

**Spacer**

A4627 Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler

S8100 Holding chamber or spacer for use with an Inhaler or nebulizer; without mask

S8101 Holding chamber or spacer for use with an inhaler or nebulizer; with mask

Q. What **documentation** is required for reporting a telemedicine service, such as a 99213?

A. The documentation requirements for the service reported via telemedicine will not change. You will still have to meet the requirements of a given code level.

For example, if you report a 99213, you will still be required to document at least 2 of the following 3:

- An expanded problem focused history;
- An expanded problem focused examination;
- Medical decision making of low complexity.

or

If you are documenting that you are coding based on time (>50% counseling or coordination of care), you must document both total time and total time spent in counseling and/or care coordination.

Please note that the AAP is aware that CMS is making allowances for using the 2021 office-based E/M service requirements. What that means is that if your payer is following CMS, you may report the office-based E/M services (99201-99215) based on time (regardless of how it is spent) or MDM only (do not use history or exam).

Q. If we have to bill a telemedicine service (using modifier 95) and another service that requires modifier 25 to be used in addition, which modifier should be listed first?

A. In general the rule is to report the “payment” modifier before any other descriptive modifier. Since both modifier 25 and 95 can impact payment, list modifier 25 first.
Q. I heard from the AMA that we can report “telemedicine” using audio only – like a telephone call? Is that true?

A. The AMA owns CPT and is making allowances during this COVID-19 outbreak to allow telemedicine services to no longer require the “video” portion if it is not available -- yet still report the service as a telemedicine service with modifier 95. Please refer to the AMA CPT Guidance Document for more details.

It should be noted that in the CMS Interim Final Rule With Comment Period (IFC), CMS is continuing to require that audio-only visits be reported with the telephone codes (99441-99443 or 98966-98968) instead of as a telemedicine service, which they will now pay for based on the current published RVUs. In addition, the HHS Office for Civil Rights (OCR) is exercising enforcement discretion and waiving penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the PHE.

As always, please check with your payers before implementing any new coding guidance -- and make sure to get any policy declarations in writing.

Q. Is it true that I can report a telehealth transmission fee?

A. At the present time, no, you cannot. Where the patient receives services is known as the originating (or hosting) site. The patient’s home is generally not an eligible originating site, but the 1135 waiver now allows this exception. Only the originating/hosting site is allowed to report Q3014 (ie, telehealth originating site facility fee). Where the physician is located is the distant site. Distant sites are not eligible to report Q3014 – even within the exceptions provided by the 1135 waiver.

However, physicians should see if their payers might allow payment for the incremental expense associated with developing and sustaining a telemedicine program. For example, a payer can allow a physician to additionally report HCPCS Level II code T1014 (telehealth transmission, per minute, professional services bill separately) or pay the physician a small telemedicine capitation fee.

Q. We have residents in our clinic. We still want our residents to see patients; however, most of our services are conducted through telemedicine. How will that work for our teaching physicians? In addition, we are a primary care teaching site, what Office Visit codes can we report?

A. From the CMS Interim Final Rule With Comment Period (IFC): The requirement for the presence of a teaching physician can be met, at a minimum, through direct supervision by interactive telecommunications technology. Use of real-time, audio and video telecommunications technology allows for the teaching physician to interact with the resident through virtual means, thereby allowing them to furnish assistance and direction without requiring the teaching physician’s physical presence for the key portion of the service.

Additionally, for the duration of the PHE, CMS is allowing all levels of Office Visit services (ie, levels 1-5) under the PCER.

Q. How do I report disposable personal protective equipment (PPE)?

A. Two pairs of non-sterile gloves are already including in the medical supply package for every Evaluation and Management (E/M) service.
However, you may separately report other PPE items using CPT code 99070 *(Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)). Below please find the 2020 CMS Assigned Cost for each item.

<table>
<thead>
<tr>
<th>PPE</th>
<th>CMS Assigned Cost</th>
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<tbody>
<tr>
<td>Shoe covers, surgical</td>
<td>$0.219/pair</td>
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<tr>
<td>Safety glasses</td>
<td>$2.411/item</td>
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<tr>
<td>Staff gown, impervious</td>
<td>$1.186/item</td>
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<tr>
<td>Surgical mask, with face shield</td>
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