

# COVID-19 RESOURCE for HEALTH CARE PROVIDERS



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Coronavirus Guidance related to Medicaid/ Medicare, Telehealth, HIPAA, CPT Codes, as well as Ohio-Specific and Federal information and more.

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## Centers for Medicare and Medicaid Services

### General Information for Health Care Providers

#### **1. Are there any waivers regarding provider location?**

CMS plans to temporarily waive requirements that out-of-state providers be licensed in the state where they are providing services when they are licensed in another state. This applies to Medicare and Medicaid.

#### **2. How can providers enroll in Medicare/Medicaid during this time period?**

CMS will establish a toll-free hotline for non-certified Part B suppliers, physicians and non-physician practitioners to enroll and receive temporary Medicare billing privileges. In doing so, CMS will waive the following screening requirements: (1) Application Fee (found in 42 C.F.R 424.514); (2) Criminal background checks associated with FCBC (found in 42 C.F.R 424.518); and (3) Site visits (found in 42 C.F.R 424.517).

In addition to the above, CMS will postpone all revalidation actions, allow licensed providers to render services outside of their state of enrollment, and expedite any pending or new applications from providers.

### General Questions for State Medicaid and Children's Health Insurance Program (CHIP) Agencies

#### General Questions

#### **1. Is CMS providing any flexibilities to seek Section 1135 waiver requests?**

Yes. The following are examples of flexibilities that a state and/or territory may seek through a Section 1135 waiver request:

- Waive prior authorization requirements in fee -for-service programs.
- Permits providers located out of state/territory to provide care to another state's Medicaid enrollees impacted by the emergency.
- Temporarily suspend certain provider enrollment and revalidation requirements to increase access to care.
- Temporarily waive requirements that physicians and other health care professionals be licensed in the state in which they are providing services, so long as they have an equivalent licensing in another state.

- Temporarily suspend requirements for certain pre-admission and annual screenings for nursing home residents.
- 1. States and territories are encouraged to assess their needs and request these available flexibilities, which are more completely outlined in the Medicaid and CHIP Disaster Response Toolkit. For more information and to access the toolkit, visit: [Medicaid Disaster Response Toolkit](#).
- 2. **Are there any exceptions to the federal timeliness standards for processing Medicaid and CHIP applications?**

Yes. States are excused from meeting the timeliness standards for processing applications due to administrative or another emergency beyond the agency's control. This would include a public health emergency, like COVID-19, during which workforce shortages may impact the agency's ability to process applications timely and/or impacted individuals may be unable to receive or respond to notices or provide information needed to complete the application process. To exercise this flexibility, a Medicaid SPA is not needed. States relying on a timeliness standard exception on a case-by-case basis must document the reason for the delay in the individual's case record.

States seeking to invoke a timeliness standard exception for a broader cohort of cases (for example, all applications in a defined geographic area) are advised to not only document the exception in the applicant's case record, but also to obtain CMS concurrence that the exception is warranted under the circumstances.

CHIP agencies should submit a disaster relief state plan amendment to utilize flexibilities related to application processing. States that already have a disaster relief state plan amendment that includes flexibilities related to application processing will just need to notify CMS that they are activating this flexibility.

- 3. **Are there any exceptions to the timeliness standards for processing Medicaid and CHIP renewals?**

Yes. States have flexibility in meeting the timeliness standards for renewing Medicaid eligibility during an administrative or other emergency beyond the agency's control. This would include a public health emergency, like COVID-19, during which workforce shortages may impact the agency's ability to complete timely renewals and/or impacted individuals may be unable to receive or respond to notices or provide information needed to complete the renewal process. *In such cases, the state must continue to furnish Medicaid to eligible beneficiaries until they are determined ineligible. A state plan amendment for Medicaid is not needed.*

States relying on a timeliness standard exception on a case-by-case basis must document the reason for the delay in the individual's case record. States seeking to invoke a timeliness standard exception for a broader cohort of cases (for example, all renewals in a defined geographic area) are advised to not only document the exception in the beneficiary's case record, but also to obtain CMS concurrence that the exception is warranted under the circumstances.

CHIP agencies should submit a disaster relief state plan amendment to utilize flexibilities related to redetermination processing. States that already have a disaster relief state plan amendment that includes flexibilities related to redetermination processing will just need to notify CMS that they are activating this flexibility.

**4. Can a state extend eligibility for current beneficiaries subject to an emergency or disaster so that they can continue to receive coverage beyond their renewal date, even if no longer eligible?**

*As described above, states have flexibility in meeting the timeliness standards for renewing Medicaid eligibility during an administrative or other emergency beyond the agency's control. Beyond those flexibilities, for eligibility groups excepted from the MAGI-based methodologies, states have the option to renew eligibility once every 12 months or more frequently than once every 12 months. States that have elected to conduct more frequent renewals for MAGI-excepted groups may submit a state plan amendment to extend the renewal period to 12 months.*

Under the Medicaid state plan, states can also elect to extend coverage to certain additional individuals statewide by increasing effective income standards (and, for individuals subject to an asset test, resource standards) for some populations and/or adopt an optional eligibility group to cover other populations, when allowable under the statute. A state plan amendment would be needed to do so. However, income and resource standards and eligibility groups in the state plan may not apply narrowly to only those affected by a particular diagnosis, such as COVID-19. CMS is available to provide technical assistance to states seeking to extend coverage to additional populations during a disaster or other emergency.

CHIP agencies may extend eligibility through a disaster relief state plan amendment. States that already have a disaster relief state plan amendment that includes flexibilities related to extending eligibility will just need to notify CMS that they are activating this flexibility.

**5. Will CMS issue guidance on loosening prior authorization requirements for medication and supplies for medically fragile children and other populations who may be quarantined?**

The answer to this question depends on whether the child receives their care through Fee-For-Service (FFS) or managed care:

- **FFS / Supplies:** States have flexibility to establish and manage prior authorization processes without CMS approval. Given that medically fragile children are subject to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements, there should be no hard limits on services provided to these children. A SPA may be needed, depending on the state's goals.
- **FFS/Pharmacy:** States have flexibility to establish the prior authorization process without CMS approval, including length of time and units approved. A state may need to amend their SPA for a change in quantity dispensed.
- **Managed Care:** Under Medicaid managed care, states may develop the specific standards and criteria that best meet the needs of their program, including accelerated or relaxed requirements during times of emergency. Federal law does not prohibit or limit states from requiring managed care plans to temporarily suspend prior authorization requirements, extend prior authorizations through the termination of the emergency declaration, and expedite processing of new prior authorizations with flexibility in documentation (e.g., physician signatures).

**6. Can states provide an additional month of medication to a beneficiary when their Medicaid eligibility is ending?**

States have flexibility to determine the quantity of medication covered per prescription fill. Federal financial participation (FFP) is available for a prescription if the date of service falls during the individual's Medicaid eligibility period.

**7. Is the test for the detection of COVID-19 coverable under Medicaid's mandatory laboratory benefit?**

Yes. The test meets the criteria for a mandatory laboratory service as described at 1905(a)(3) and 42 C.F.R. § 440.30. The test must be ordered and provided by or under the direction of a physician or other licensed practitioner within the appropriate scope of practice as defined by the state, or ordered by a physician, but provided by referral laboratory. To meet this definition, the test must be provided in an office or similar facility other than a hospital outpatient department or clinic and furnished by a laboratory that meets Clinical Laboratory Improvement Amendments (CLIA) requirements at Part 493 of the Code of Federal Regulations. Tests that do not meet these criteria may still be covered under the optional diagnostic benefit.

If a state's current Medicaid cost sharing policies include cost sharing for the test for the detection of COVID-19, the state can submit a SPA to eliminate the cost sharing for that test. For CHIP, states can stop charging copayments for particular items or services through a CHIP disaster relief SPA.

## Cost-Sharing Flexibilities

### **1. What authority is available to not charge copayments during a public health emergency?**

If a state wishes to stop charging copayments for particular items or services in Medicaid (e.g., doctor visits or inpatient hospital services), the state can submit a SPA. However, exempting individuals from copayments cannot be applied narrowly to only those affected by a particular diagnosis, such as COVID-19. Rather, a copayment exemption under the state plan would need to apply to everyone who accesses a particular item or service. Alternatively, the state could request section 1115 authority to temporarily suspend copayments only for individuals needing treatment for COVID-19 infection.

States can stop charging copayments for particular items or services in CHIP through a CHIP disaster relief SPA.

## Workforce Flexibilities

### **1. What options are available if a state experiences a shortage of health care workers because of COVID-19?**

To address provider shortages for individuals receiving 1915(c) waiver services, states can use Appendix K to expand provider qualifications (e.g., where a provider must be 21 years old, states could modify the age requirement to 18); add additional providers (including allowance of payment to family members and legally responsible relatives); add services, such as a live-in care giver; and temporarily adjust rates to entice more individuals into the workforce.

For state plan services, a SPA can increase the types of providers a state authorizes to deliver services. As always, states should be mindful of state-level requirements that might impact provider flexibility in delegation of authority.

Additionally, states have broad ability to cover telehealth through Medicaid, and no federal approval is needed for state Medicaid programs to reimburse for telehealth services in the same manner or at the same rate paid for face-to-face services, visits, or consultations. A SPA is necessary to accommodate any revisions to payment methodology to account for telehealth costs.

To address state staff shortages, the Appendix K process can also be utilized for case managers under 1915(c) to permit the use of telehealth or telephonic consultations in place of typical face-to-face requirements. Under 1915(i), existing regulatory flexibility at 42 C.F.R. § 441.720(a) permits use of telehealth in place of face-to-face assessments when certain conditions are met.

**2. What precautions can states take to protect home health workers, personal care workers, and eligibility workers from contracting COVID-19?**

CMS supports the Centers for Disease Control and Prevention (CDC) guidance on workforce protections. CMS has also issued relevant guidance at the following link: [here](#). Any additional guidance will be posted to [Agency Information Emergency Page](#).

To account for increased costs in personal protective equipment (PPE) for home care workers, a SPA or Appendix K for a 1915(c) waiver could be submitted to amend payment methodologies for impacted services.

**3. What flexibility exists to allow states to utilize first responders (emergency medical technicians (EMTs), fire fighters, etc.) to administer testing for COVID-19?**

Depending on the specificity in the existing Medicaid state plan, a SPA may be necessary to add first responders as testing providers. CMS notes that state laws may have implications for the scope of providers able to perform these activities.

In addition, third party liability provisions apply for services covered across the Medicaid program, and states could utilize existing mechanisms to ensure compliance.

**Miscellaneous**

**1. In the event of a public health emergency in which a healthcare facility experiences an acute critical staffing shortage, including a staffing shortage due to infectious disease, and temporarily utilizes federal health care workers (e.g., US Public Health Services Commissioned Corps Officers) in place of facility staff, may the facility continue to bill the Medicaid program for the services provided to beneficiaries?**

Providers are generally prohibited from billing the Medicaid program and states may not receive FFP for practitioner services provided by federally employed health care workers. To the extent care provided by a federal employee supplants the costs of practitioner or non-practitioner services that are bundled into a rate that includes multiple service costs, the provider's payment would need to be allocated and the state's claim for FFP would need to be reduced to account for service costs associated with federally employed practitioners. For example, if a nursing facility is staffed in part by federally employed health care workers and is paid a per diem rate for Medicaid services, the state's claim of FFP for the per diem rate would need to be reduced for all care costs assumed for services provided by federal workers. In such instances, during a public emergency, the state may continue to pay the nursing facility the full per diem rate and recoup funds from the provider once data is available to properly allocate service costs. Such an allocation may be conducted using cost data from a nursing facility's cost report or, if feasible, by reducing the per diem rates by cost factors associated with care costs assumed by the federal health care worker.

The data used to allocate cost must be auditable and claimed FFP associated with the federally employed worker must be returned to CMS. CMS will work with state to ensure this process is conducted within an appropriate time frame following acceptance of federal assistance. In the interim, states may continue to pay providers in accordance with Medicaid state plan methodologies and CMS will work with the state on a case-by-case basis to ensure that a reasonable allocation method is developed in accordance with applicable cost allocation requirements.

## Coverage and Benefits Related to COVID-19 Medicaid and CHIP

### Medicaid / CHIP Benefits

Medicaid and CHIP programs cover a broad range of benefits, which may vary by state. Some benefits are mandatory which means states are required to provide them while other benefits are optional for states to provide. More information about some benefits is described below:

- Testing, Diagnostics and Laboratory Services
  - Include any medical procedures or supplies recommended by a physician or other licensed practitioner to enable him/her to identify the existence, nature or extent of illness and whether a person is sick.
  - These services are an optional benefit category and can vary by state.
  - Children are eligible to receive all medically necessary testing and diagnostic services.
  - Laboratory and X-ray services are a mandatory benefit in Medicaid and these services are covered and reimbursed in all states.
  - Specific questions about these testing, diagnostic and laboratory services should be directed to the respective state Medicaid and CHIP agency.
  
- Immunizations
  - Children:
    - Medicaid and CHIP cover recommended vaccines for children without cost sharing.
  - Adults:
    - In states that have expanded Medicaid, states must cover preventive services including vaccinations without cost sharing for adults. States have flexibility to determine whether to provide coverage of vaccines for adults covered in other eligibility groups, like low-income parents.
  
- Hospital Care (Inpatient and Outpatient Service)
  - Beneficiaries can receive a range of inpatient hospital inpatient services for their care and treatment under the direction of a physician or dentist.

- Beneficiaries can receive a range of hospital outpatient services including preventive, diagnostic and testing, therapeutic, rehabilitative and palliative care under the direction of a physician or dentist.
- Under Medicaid, states are required to provide both inpatient and outpatient hospital services to beneficiaries. For CHIP, all states provide coverage of hospital care for children and pregnant women.
- Prescription Drugs
  - Beneficiaries can receive a range of prescription drugs through Medicaid and CHIP.
  - States may choose to cover specific categories of Over-the-Counter medications. Many states cover categories for fever relief, cough preparations as well as medications related to the treatment of virus symptoms.
  - In some cases, states may subject some medications to prior authorization requirements or other utilization management tools.
  - Prescription drug services, for both Medicaid and CHIP, are an optional benefit, although all states cover prescription services.
- Nursing Facilities
  - Medicaid provides nursing facility services to low-income Medicaid beneficiaries determined eligible to receive those services in certified nursing homes.
  - Medicaid certified nursing homes primarily provide three types of services:
    - **Skilled nursing** or medical care and related services
    - **Rehabilitation** needed due to injury, disability, or illness
    - **Long term care** —health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition
  - A nursing facility is one of many settings for long-term care, including or other services and supports outside of an institution, provided by Medicaid or other state agencies.
  - Residents may be charged for some services provided in a nursing facility.
  - This is a mandatory benefit and coverage rules vary by state.
- Emergency Transportation
  - Emergency Transportation is appropriate when the beneficiary needs immediate transportation for evaluation or stabilization for an emergency medical condition, which means a medical condition that is so severe and acute (including severe pain) that a lack of immediate medical attention could result in placing the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
  - All states are required to cover emergency medical transportation. States provide necessary non-emergency transportation to providers' offices.

- Child Health Services
  - Medicaid beneficiaries under age 21 and CHIP beneficiaries in some states are eligible for medically necessary services that may be covered, even if the service is not covered for adults.
  - The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services.
  - States are required to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines. EPSDT is made up of screening, diagnostic, and treatment services.
  - Please see the link for more information about these child health services: [here](#).
  
- Telehealth
  - Telehealth (or telemonitoring) is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance.
  - States have broad ability to cover telehealth for the delivery of Medicaid-covered services.

### Cost Sharing and Premiums

Cost sharing for most Medicaid and CHIP services is nominal or limited, and maximum out of pocket costs are typically capped at five percent of family income. Certain vulnerable groups, such as children and pregnant women, are *exempt from most out of pocket costs* and copayments and coinsurance cannot be charged for certain services such as emergency and preventive services.

States have the option to charge premiums and to establish out-of-pocket spending (cost sharing) requirements for Medicaid enrollees. Out of pocket costs may include copayments, coinsurance, deductibles, and other similar charges. States can charge premiums and enrollment fees for some Medicaid beneficiaries. Because Medicaid covers particularly low-income and often very sick patients, services cannot be withheld for failure to pay, but enrollees may be held liable for unpaid copayments. Check with individual state Medicaid/CHIP programs for specifics about cost sharing.

### Guidance for use of Certain Industrial Respirators by Health Care Personnel

The CDC have updated their Personal Protective Equipment (PPE) recommendations for health care workers involved in the care of patients with known or suspected COVID-19. At this time, these recommendations will be considered by CMS surveyors to determine if Medicare and Medicaid providers and suppliers are complying with infection control protocols:

- Based on local and regional situational analysis of PPE supplies, facemasks are an acceptable temporary alternative when the supply chain of respirators cannot meet the demand. During this time, available respirators should be prioritized for procedures that are likely to generate respiratory aerosols, which would pose the highest exposure risk to Health Care Providers (HCP).
  - Facemasks protect the wearer from splashes and sprays.
  - Respirators, which filter inspired air, offer respiratory protection.
- When the supply chain is restored, facilities with a respiratory protection program should return to use of respirators for patients with known or suspected COVID-19. Facilities that do not currently have a respiratory protection program, but care for patients infected with pathogens for which a respirator is recommended, should implement a respiratory protection program.
- Eye protection, medical gown, and gloves continue to be recommended.
  - If there are shortages of medical gowns, they should be prioritized for aerosol-generating procedures, care activities where splashes and sprays are anticipated, and high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of HCP.
- Updated recommendations regarding the need for an airborne infection isolation room (AIIR).
  - Patients with known or suspected COVID-19 should be cared for in a single-person room with the door closed. AIIRs should be reserved for patients undergoing aerosol-generating procedures.
- Updated information based on currently available information about COVID-19 and the current situation in the United States, which includes reports of cases of community transmission, infections identified in HCP, and shortages of facemasks, N95 filtering facepiece respirators (FFRs) (commonly known as N95 respirators), and gowns.
  - Increased emphasis on early identification and implementation of source control (i.e., putting a face mask on patients presenting with symptoms of respiratory infection).

Additional information on CDC's recommendations above can be found [here](#).

Further, the FDA approved the CDC request for an emergency use authorization (EUA) to allow health care personnel to use certain industrial respirators during the COVID-19 outbreak in health care settings. The FDA concluded that respirators approved by the National Institute for Occupational Safety and Health (NIOSH), but not currently meeting the FDA's requirements, may be effective in preventing health care personnel from airborne exposure, including COVID-19, which can cause serious or life-threatening disease, including severe respiratory illness.

This action allows the NIOSH-approved respirators not currently regulated by the FDA to be used in a health care setting by health care personnel during the COVID-19 outbreak, thereby maximizing the number of respirators available to meet the needs of the U.S. health care system.

## Frequently Asked Questions to Assist Medicare Providers

### Physicians' Services

#### **1. Does Medicare pay for a doctor or non-physician practitioner (NPP) to furnish care in a beneficiary's home?**

Medicare pays for evaluation and management (E/M) and other services furnished in a beneficiary's home by a physician or NPP. Additionally, Medicare makes payment for a number of non-face-to-face services that can be used to assess and manage a beneficiary's conditions. These include care management services, remote patient monitoring services, and communication technology-based services.

#### **2. Does Medicare pay for a doctor, NPP, or nurse to call or use other technology to communicate with a patient?**

Medicare pays for several services that are brief communications with practitioners for specific purposes. These services can be furnished via a number of communication technology modalities. For example, HCPCS code G2012 (virtual check-in) can be furnished using synchronous technology such as a telephone call. HCPCS code G2010 (Remote evaluation of recorded video and/or images submitted by an established patient) can be furnished using asynchronous technology such as e-mail. And CPT codes 99421-99423 (patient-initiated digital communication) and HCPCS codes G2061-G2063 (online assessment) can be furnished using an online patient portal. We expect that these services will be initiated by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient initiation.

## Drugs & Vaccines Under Part B

### **1. Will Medicare Part B pay for vaccinations of Medicare beneficiaries?**

Medicare Part B pays for preventive Hepatitis B vaccinations for high-and intermediate-risk beneficiaries and also for influenza and pneumococcal vaccinations for all Medicare beneficiaries. Medicare Part B will also pay for medically reasonable and necessary vaccinations of beneficiaries against a microbial agent or its derivatives (e.g., tetanus toxin, Hepatitis A) following likely exposure in accordance with normal Medicare coverage rules.

Under current law, once a vaccine becomes available for COVID-19, Medicare will cover the vaccine under Part D. All Part D plans will be required to cover the vaccine.

### **2. If new drugs are created to treat COVID-19, can they be billed?**

New drugs that are covered under Medicare Part B, including new antiviral drugs, can be paid by the Medicare Administrative Contractors until they receive a code and are on the pricing files. New drugs that are covered under Medicare Part D can be billed to the beneficiary's Part D plan.

### **3. If a State distributes CDC's Strategic National Stockpile (SNS) drugs to hospitals, what are the Medicare billing rules? How should hospitals handle billing for services that involve the use of SNS provided drugs?**

For services rendered to Medicare beneficiaries, standard Medicare billing rules apply. Based on existing policy, providers may not seek reimbursement for no cost items such as SNS drugs. Specifically, the policy is described in the CMS Internet Only Manual Pub. 100-04, Chapter 32, Section 67 which states that provider may not seek reimbursement for no cost items as noted in Section 1862(a)(2) of the Social Security Act.

### **4. Will Medicare Part B cover a 90-day supply of drugs in the event that a pandemic occurs, when such drugs are needed for a patient's chronic condition?**

With respect to drugs covered under Part B, with the exception of immunosuppressive drugs -- which are generally limited to a 30-day supply -- but including drugs that need to be administered through Durable Medical Equipment, local MACs have discretion to pay for a greater-than-30-day supply of drugs. When considering whether to pay for a greater-than-30day supply of drugs, MACs will take into account the nature of the particular drug, the patient's diagnosis, the extent and likely duration of disruptions to the drug supply chain during an emergency, and other relevant factors that would be applicable when making a local determination as to whether, on the date of service, an extended supply of the drug was reasonable and necessary.

With respect to immunosuppressive drugs, although Medicare would customarily not pay for

more than a 30-day supply because dosage frequently diminishes over a period of time and it is not uncommon for the physician to change the prescription from one drug to another. In the event of an emergency, local MACs may consider allowing payment for a medically necessary, greater-than-30-day supply of Medicare-covered, immunosuppressive drugs on a case-by-case basis taking local considerations into account.

#### **5. Can a Medicare beneficiary receive more than a 30-day supply of Medicare Part B covered drugs during an emergency?**

In most situations where there are specific limits on coverage of additional quantities or time limited coverage periods that are 30 days or less, Medicare Part B does not pay for additional quantities. For example, oral anti-emetic drugs are covered only when they are used immediately before, at, or within 48 hours after administration of an anticancer chemotherapeutic agent. For immunosuppressive drugs, claims processing contractors will generally not consider a supply of immunosuppressive drugs in excess of 30 days to be reasonable and necessary and will deny payment, unless there are special circumstances. Information on exceptions for special circumstances would be made available by the local MAC that processes a provider or supplier's immunosuppressive drug claims. Source: [here](#). See section 80.3.3, Special Requirements for Immunosuppressive Drugs)

## **Medicare Coverage and Payment Related to Covid-19**

### Original Medicare

#### Diagnostic Tests

Medicare Part B, which includes a variety of outpatient services, covers medically necessary clinical diagnostic laboratory tests when a doctor or other practitioner orders them. Medically necessary clinical diagnostic laboratory tests are generally not subject to coinsurance or deductible.

Medicare Part B also covers medically necessary imaging tests, such as computed tomography (CT) scans, as needed for treatment purposes for lung infections (not for screening asymptomatic patients). For those imaging tests paid by Part B, beneficiary coinsurance and deductible would apply.

If the Part B deductible (\$198 in 2020) applies to the Part B services, beneficiaries must pay all costs (up to the Medicare-approved amount) until the beneficiary meets the yearly Part B deductible.

After the beneficiary's deductible is met, Medicare pays its share and beneficiaries typically pay 20% of the Medicare-approved amount of the service (except laboratory tests), if the doctor or other health care provider accepts assignment. There's no yearly limit for what a beneficiary pays out-of-pocket.

### Vaccines

Medicare Part B pays for certain preventive vaccines (influenza, pneumococcal, and Hepatitis B) and coinsurance and deductible do not apply to preventive vaccines. Medicare Part B also pays for other vaccines directly related to medically necessary treatment of an injury or direct exposure to a disease or condition. For example, Medicare would cover a tetanus vaccine for a beneficiary who steps on a rusty nail. For these other medically necessary vaccines, beneficiary coinsurance and deductible would apply.

### Inpatient Hospital Care Services

Medicare Part A covers medically necessary inpatient hospital care. This coverage includes semi-private rooms, meals, general nursing, imaging, drugs as well as other hospital services and supplies as part of inpatient hospital treatment. Inpatient hospital treatment includes care from acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, inpatient care as part of a qualifying clinical research study, and inpatient mental health care given in a psychiatric hospital or psychiatric unit within a hospital.

Medicare beneficiaries may pay a deductible for hospital services. Under Original Medicare, for hospital inpatient services, beneficiaries pay a deductible of \$1,408 and no coinsurance for days 1– 60 of each benefit period. Beneficiaries pay a coinsurance amount of \$352 per day for days 61– 90 of each benefit period. There is a coinsurance amount per "lifetime reserve day" after day 90 of each benefit period (up to 60 days over a beneficiary's lifetime).

Beneficiaries pay all costs for each day after all the lifetime reserve days are used. In addition, inpatient psychiatric care in a freestanding psychiatric hospital is limited to 190 days in a beneficiary's lifetime.

### Inpatient Hospital Quarantines

There may be times when beneficiaries with the virus need to be quarantined in a hospital private room to avoid infecting other individuals. These patients may not meet the need for acute inpatient care any longer but may remain in the hospital for public health reasons. Hospitals having both private and semiprivate accommodations may not charge the patient a differential for a private room if the private room is medically necessary.

Patients who would have been otherwise discharged from the hospital after an inpatient stay but are instead remaining in the hospital under quarantine would not have to pay an additional deductible for quarantine in a hospital.

If a Medicare beneficiary is a hospital inpatient for medically necessary care, Medicare will pay hospitals the diagnosis-related group (DRG) rate and any cost outliers for the entire stay, including any the quarantine time when the patient does not meet the need for acute inpatient care, until the Medicare patient is discharged. The DRG rate (and cost outliers as applicable) includes the payments for when a patient needs to be isolated or quarantined in a private room.

### Ambulatory Services in a Hospital or Other Location

Medicare Part B covers medically necessary ambulatory services, including doctors' services, hospital outpatient department services, home health services, durable medical equipment, mental health services, and other medical services. Coinsurance and deductible would generally apply depending on the service. In the event a patient is quarantined in an ambulatory setting, the existing Medicare payments for medically necessary services apply.

### Requests for Prescription Refills

For Part B drugs, when considering whether to pay for a greater-than-30-day-supply of drugs, in general, Medicare and its contractors, known as Medicare Administrative Contractors or MACs, will, on a case-by-case, basis, consider each request and make decisions locally.

In general, local Medicare contractors will take into account the nature of the particular Part B drug (including Part B immunosuppressive drugs), the patient's diagnosis, the extent and likely duration of disruptions to the drug supply chain during an emergency, and other relevant factors that would be applicable when making a determination as to whether, on the date of service, an extended supply of the drug was reasonable and necessary.

### Emergency Ambulance Transportation

Medicare covers ground ambulance transportation when beneficiaries need to be transported to a hospital, critical access hospital, or skilled nursing facility for medically necessary services when transportation in any other vehicle could endanger the beneficiary's health. A ground ambulance emergency transportation may temporarily stop at a doctor's office without affecting the coverage status of the transport in certain circumstances, however, in general the physician's office is not a covered destination. Medicare may pay for emergency ambulance transportation in an airplane or helicopter to a hospital if the beneficiaries needs immediate and rapid ambulance transportation that ground transportation can't provide.

Should a facility which would normally be the nearest appropriate facility be unavailable during an emergency, Medicare may pay for transportation to another facility so long as that facility is the nearest facility that is available and equipped to provide the needed care for the illness or injury involved.

In some cases, Medicare may pay for limited, medically necessary, nonemergency ambulance transportation if the doctor writes an order stating that ambulance transportation is medically necessary. For example, beneficiaries may need a medically necessary nonemergency ambulance transport to a dialysis facility when they have End-Stage Renal Disease. There is a current Medicare model testing prior authorization for individuals receiving scheduled, nonemergency ambulance transportation for 3 or more round trips in a 10-day period or at least once a week for 3 weeks or more in certain states. The Medicare coinsurance and deductible would apply to these Part B services.

Medicare pays for ambulance transports under the Ambulance Fee Schedule. This payment amount includes a base rate payment (level of service provided) plus a separate payment for mileage to the nearest appropriate facility and also cover both the transport of the beneficiary to the nearest appropriate facility and all medically necessary covered items and services (such as oxygen, drugs, extra attendants, and electrocardiogram testing) associated with the transport.

## Medicare Advantage (Part C) and Part D

Medicare Advantage (also known as “Part C”) is an “all in one” alternative to Original Medicare. Medicare Advantage plans cover Medicare Part A and Part B services, and usually prescription drugs covered under Medicare Part D. These plans also may offer extra benefits Original Medicare doesn’t cover. Medicare Part D, also called the Medicare prescription drug benefit, is an optional federal-government program to help Medicare beneficiaries pay for prescription drugs not covered under Part B through prescription drug insurance.

### Medicare Advantage Coverage

Medicare Advantage plans must cover all medically necessary Part A and B services covered under Original Medicare for all enrollees. Medicare Advantage plans can also cover items and services beyond those covered by Original Medicare, such as vision, dental, and over-the-counter products, among other things. These items and services are typically referred to as “supplemental benefits.”

### Medicare Advantage Cost Sharing - “Surprise Billing”

Medicare Advantage plan enrollees are generally protected from “surprise billing” which is when an enrollee receives unexpected bills from out-of-network providers. Surprise billing most commonly occurs when patients either receive care from an out-of-network provider they had

reasonably assumed was in-network or received out-of-network care in an emergency when they had limited, if any, ability to choose their provider. When Medicare Advantage enrollees obtain plan-covered services (e.g., covered under the plan's normal rules, or when an HMO arranges for or directs out of network care) in an HMO, PPO, or Regional PPO, they may not be charged or held liable for more than plan-allowed cost-sharing.

Additionally, CMS advises Medicare Advantage (MA) organizations that they may waive or reduce enrollee cost-sharing for Novel Coronavirus (COVID-19) laboratory tests effective immediately provided that MA organizations waive or reduce cost-sharing for all plan enrollees on a uniform basis. Specifically, CMS will exercise its enforcement discretion regarding the administration of MA organizations benefit packages as approved by CMS in conjunction with implementing a voluntary waiver or reduction of cost-sharing for COVID-19 laboratory tests as described. CMS consulted with the Office of Inspector General (OIG) and OIG advised that should an MA organization choose to voluntarily waive or reduce enrollee cost-sharing for COVID-19 laboratory tests, as approved by CMS in this advisory, such waivers or reductions would satisfy the safe harbor to the Federal anti-kickback statute set forth at 42 CFR 1001.952(l).

Nothing in this guidance speaks to the arrangements between MA organizations and their contracted providers or facilities.

## Part D Coverage

Each Part D Sponsor that offers prescription drug coverage must provide a standard level of coverage to ensure beneficiaries have adequate access to Part D drugs. Many Part D Sponsors offer plans with different levels of coverage many of which exceed CMS's minimum requirements.

### Vaccines

Under current law, once a vaccine becomes available for COVID-19, Medicare will cover the vaccine under Part D. All Part D plans will be required to cover the vaccine.

### Prior Authorization

Consistent with flexibilities available to Medicare Advantage Organizations and Part D Sponsors with respect to other items and services, MAOs and Part D Sponsors may choose to waive plan prior authorization requirements that otherwise would apply to tests or services related to COVID-19.

## Information Related to COVID–19 Individual and Small Group Market Insurance Coverage

Existing federal rules governing health insurance coverage, including with respect to viral infections, apply to the diagnosis and treatment of coronavirus (COVID-19). This includes plans purchased through HealthCare.gov. Patients should contact their insurer to determine specific benefits and coverage policies. Benefit and coverage details may vary by state and by plan. States may choose to work with plans and issuers to determine the coverage and cost-sharing parameters for COVID-19 related diagnoses, treatments, equipment, telehealth and home health services, and other related costs.

### Diagnosics & Laboratory Services

Laboratory services are a category of Essential Health Benefits (EHB) that individual and small group market issuers are generally required by law to include in their benefit packages. However, whether any particular diagnostic or laboratory service is covered by a plan varies, and is based on the specific benchmark plan selected by each state and the terms of the plan. Large group market plans and self-insured plans are not subject to EHB coverage requirements. You should check with your health insurance company to determine coverage for lab tests and related services for the diagnosis and treatment of COVID-19. Standard cost sharing may apply for these services.

### Vaccines

If a vaccine is developed for COVID-19 and approved for use by the FDA, further guidance may be issued regarding whether the vaccine would need to be covered as a preventive service for which no cost sharing would be charged.

### Hospitalization & Ambulatory Patient Services

Hospitalization, ambulatory patient, and emergency services are categories of EHB that individual and small group market issuers are generally required by law to include in their benefit packages. However, whether any particular hospitalization, ambulatory patient, or emergency service is covered by plans varies, and is based on the specific benchmark plan selected by each state and the terms of the plan. Large group market plans and self-insured plans are not subject to EHB coverage requirements. You should check with your health insurance company to determine coverage for physician and hospital related services for the diagnosis and treatment of COVID-19. Standard cost sharing may apply for these services.

## Telehealth

Telehealth services or home health visits may already be covered by many health insurance companies. You should check with your health insurance company to determine whether these services are covered and whether any cost-sharing requirements apply.

## Prescription Drugs

Prescription drugs are a category of EHB that individual and small group market issuers are generally required by law to include in their benefit packages. However, whether any particular prescription drug is covered by plans varies and is based on the specific benchmark plan selected by each state and the terms of the plan. Prior authorization for prescription drugs, including for any treatment for COVID-19 that may become available, may still apply, so you should check with your health insurance company to clarify any future changes to prior authorization requirements. Plans and issuers may elect to apply prior authorization for treatment and or refills flexibly, as circumstances warrant. Large group market plans and self-insured plans are not required to cover EHBs, so coverage would depend on the terms of the plan.

## Frequently Asked Questions on Essential Health Benefit Coverage and the Coronavirus (COVID-19)

### **1. Do the Essential Health Benefits (EHB) currently include coverage for the diagnosis and treatment of COVID-19?**

Yes. EHB generally includes coverage for the diagnosis and treatment of COVID-19. However, the exact coverage details and cost-sharing amounts for individual services may vary by plan, and some plans may require prior authorization before these services are covered. Non-grandfathered health insurance plans purchased by individuals and small employers, including qualified health plans purchased on the Exchanges, must provide coverage for ten categories of EHB.

These ten categories of benefits include, among other things, hospitalization and laboratory services. Under current regulation, each state and the District of Columbia generally determines the specific benefits that plans in that state must cover within the ten EHB categories. This standard set of benefits determined by the state is called the EHB-benchmark plan. All 51 EHB-benchmark plans currently provide coverage for the diagnosis and treatment of COVID-19.

Grandfathered health plans are health plans that were in existence as of March 23, 2010, the date of enactment of Patient Protection and Affordable Care Act (PPACA), and that are only subject to certain provisions of PPACA, as long as they maintain status as grandfathered health plans under the applicable rules. For information on the EHB-benchmark plans, see: [here](#).

Many health plans have publicly announced that COVID-19 diagnostic tests are covered benefits and will be waiving any cost-sharing that would otherwise apply to the test. Furthermore, many states are encouraging their issuers to cover a variety of COVID-19 related services, including testing and treatment, without cost-sharing, while several states have announced that health plans in the state must cover the diagnostic testing of COVID-19 without cost-sharing and waive any prior authorization requirements for such testing.

## **2. Is isolation and quarantine for the diagnosis of COVID-19 covered as EHB?**

All EHB-benchmark plans cover medically necessary hospitalizations. Medically necessary isolation and quarantine required by and under the supervision of a medical provider during a hospital admission are generally covered as EHB. The cost-sharing and specific coverage limitations associated with these services may vary by plan. For example, some plans may require prior authorization before these services are covered or may apply other limitations. Quarantine outside of a hospital setting, such as a home, is not a medical benefit, nor is it required as EHB. However, other medical benefits that occur in the home that are required by and under the supervision of a medical provider, such as home health care or telemedicine, may be covered as EHB, but may require prior authorization or be subject to cost-sharing or other limitations.

## **3. When a COVID-19 vaccine is available, will it be covered as EHB, and will issuers be permitted to require cost-sharing?**

A COVID-19 vaccine does not currently exist. However, current law and regulations require specific vaccines to be covered as EHB without cost-sharing, and before meeting any applicable deductible, when the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) recommends them. Under current regulations, if ACIP recommends a new vaccine, plans are not required to cover the vaccine until the beginning of the plan year that is 12 months after ACIP issues the recommendation. However, plans may voluntarily choose to cover a vaccine for COVID-19, with or without cost-sharing, prior to that date.

In addition, as part of a plan's responsibility to cover prescription drugs as EHB, as described above to cover ACIP-recommended vaccines, if a plan does not provide coverage of a vaccine (or other prescription drugs) on the plan's formulary enrollees may use the plan's drug exceptions process to request that the vaccine be covered under their plan, pursuant to 45 CFR 156.122(c).

## **Ohio Telehealth Services**

### **1. Does Ohio plan on expanding telehealth services?**

Yes. The Ohio Department of Medicaid is working on a draft emergency rule to expand telehealth services throughout the state. Once finalized, the rule will expand services as detailed below.

**a. What are the takeaways from the waiver of Ohio Medicaid telehealth services?**

- Expands access to telehealth for Medicaid beneficiaries by eliminating the requirement they be “established patients” with their practitioner prior to using telehealth.
- Expands the eligible originating sites – where the patient is located – by eliminating all restrictions on what constitutes a permissible site.
- Allows for use of non-secure and/or asynchronous communications to qualify for reimbursement; thus, texts, emails and phone calls all qualify as telehealth in addition to the synchronous audio/video tools permissible today.
- Enables many behavioral health services to be performed and reimbursed as telehealth, including outpatient hospital behavioral health services.
- For the first time, allows hospitals to bill and receive reimbursement for telehealth services billed on a technical (institutional) claim; the telehealth claims would be subject to the existing EAPG payment methodology, including the payment of hospital cost coverage add-ons.
- Expands the allowed providers able to offer telehealth services to audiologists, occupational and physical therapists, speech-language pathologists, and dietitians.

For a quick look at the draft rule in its initial state, please visit the ["Draft - Not Yet Filed"](#) version made available to the public as of Monday, March 16, 2020.

**2. Is telehealth available for behavioral health services?**

Yes. The Ohio Department of Mental Health and Addiction Services filed emergency rules that would expand telehealth services to certain behavioral health services. Under the OMHAS rules, “interactive videoconferencing” is found in 5122-29-31. Services that may be provided using real-time, interactive videoconferencing as a certified community behavioral health center are:

- Telehealth
- General services
- Assessments
- Counseling and therapy including groups up to 12
- Medical Activities including prescribing as allowed by Medical Board and practitioner’s licensure

- CPST Services
- Therapeutic behavioral services and psychosocial rehabilitation.

For a more detailed look at the behavioral health services available and guidance from OMHAS, please visit the document offered [here](#).

## Medicare Telehealth Services

### 1. What are the current waivers for telemedicine provided to Medicare beneficiaries?

Starting March 6, 2020, Medicare can pay for office, hospital, and patient location of residence visits furnished via telehealth across the country. A range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to their patients. Additionally, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

2. Are Community Health Centers (e.g., FQHCs) eligible for reimbursement under Medicare telehealth rules?

Medicare issues reimbursement for originating sites (defined as the location of an eligible beneficiary at the time the telemedicine occurs) and distant sites (the location of the provider issuing the service via telemedicine). As of now, health centers are not eligible to receive reimbursement as distant site providers in Medicare

#### a. What are the key takeaways from these waivers regarding “Medicare Telehealth Visits?”

- Effective for services starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to patients in broader circumstances, such as location of residence (*these visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits*).
- During this time period, Medicare will make payment for professional services furnished to beneficiaries in all areas of the country in all settings.
- More importantly for providers, Medicare will make payment for Medicare telehealth services furnished to beneficiaries in any healthcare facility and in their home.

- HHS will not conduct audits to ensure that a prior relationship existed for claims submitted during this public health emergency.

**b. What are the key takeaways from these waivers regarding “Virtual Check-Ins?”**

- Virtual check-in services can only be reported when the billing practice has an established relationship with the patient (this is not limited to only rural settings or certain locations).
- Individual services need to be agreed to by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient agreement.
- HCPCS code G2012: Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
- HCPCS code 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.
- Virtual check-ins can be conducted with a broader range of communication methods, unlike Medicare telehealth visits, which require audio and visual capabilities for real-time communication.

**c. What are the key takeaways from these waivers regarding “E-Visits?”**

- These services can only be reported when the billing practice has an established relationship with the patient. (There are no geographic or location restrictions for these visits).
- Patients communicate with their doctors by using online patient portals.
- Individual services need to be initiated by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient initiation.
- The services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G206, where appropriate.

- The Medicare coinsurance and deductible would generally apply to these services.

### 3. Where can I find more information on the Medicare Telehealth Waivers?

More information can be found on the following websites:

- [CMS Provider Fact Sheet](#)
- [Medicare Telehealth Frequently Asked Questions](#)
- [List of Payable Services under Medicare Telehealth](#)

## HIPAA

### 1. Are there any updates to HIPAA as it relates to COVID-19?

Yes. The U.S. Department of Health and Human Services provided guidance to ensure that HIPAA covered entities and business associates are aware of the ways that patient information may be shared under the HIPAA Privacy Rule during this emergency. As a provider, always remember that protections of the Privacy Rule are not set aside during an emergency.

#### a. How will HHS enforce the HIPAA Privacy and Security Rules under waived telehealth rules?

The HHS Office for Civil Rights will exercise enforcement discretion and waive 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 COVID-19 health emergency.

#### b. May a covered entity share patient information without patient authorization in the course of treatment?

Yes. Under the Privacy Rule, covered entities may disclose, without a patient's authorization, protected health information about the patient as necessary to treat the patient or to treat a different patient. Treatment includes the coordination or management of health care and related services by one or more health care providers and others, consultation between providers, and the referral of patients for treatment.

#### c. May a covered entity share patient information without patient authorization to public health authorities responsible for ensuring public health and safety?

Yes. The Privacy Rule permits covered entities to disclose needed protected health information without individual authorization under the following circumstances:

- To a public health authority, such as the CDC or a state or local health department, that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury or disability. A "public health authority" is an agency or

authority of the United States government, a State, a territory, a political subdivision of a State or territory, or Indian tribe that is responsible for public health matters as part of its official mandate, as well as a person or entity acting under a grant of authority from, or under a contract with, a public health agency. For example, a covered entity may disclose to the CDC protected health information on an ongoing basis as needed to report all prior and prospective cases of patients exposed to or suspected or confirmed to have COVID-19.

- At the direction of a public health authority, to a foreign government agency that is acting in collaboration with the public health authority.
- To persons at risk of contracting or spreading a disease or condition if other law, such as state law, authorizes the covered entity to notify such persons as necessary to prevent or control the spread of the disease or otherwise to carry out public health interventions or investigations.
- With disaster relief organizations that, like the American Red Cross, are authorized by law or by their charters to assist in disaster relief efforts, for the purpose of coordinating the notification of family members or other persons involved in the patient's care, of the patient's location, general condition, or death. It is unnecessary to obtain a patient's permission to share the information in this situation if doing so would interfere with the organization's ability to respond to the emergency.

**d. May a covered entity share protected health information with family, friends, or others involved in an individual's care and treatment? Is patient authorization required?**

Yes. A covered entity may share protected health information with a patient's family members, relatives, friends, or other persons identified by the patient as involved in the patient's care. A covered entity also may share information about a patient as necessary to identify, locate, and notify family members, guardians, or anyone else responsible for the patient's care, of the patient's location, general condition, or death. This may include, where necessary to notify family members and others, the police, the press, or the public at large.

The covered entity should get verbal permission from individuals or otherwise be able to reasonably infer that the patient does not object, when possible; if the individual is incapacitated or not available, covered entities may share information for these purposes if, in their professional judgment, doing so is in the patient's best interest. For patients who are unconscious or incapacitated, a health care provider may share relevant information about the patient with family, friends, or others involved in the patient's care or payment for care, if the health care provider determines, based on professional judgment, that doing so is in the best interests of the patient.

**e. What level of information can be shared by a covered entity?**

For most disclosures, a covered entity must make reasonable efforts to limit the information disclosed to that which is the “*minimum necessary*” to accomplish the purpose (this standard does not apply to disclosures to health care providers for treatment purposes). Covered entities may rely on representations from a public health authority or other public official that the requested information is the minimum necessary for the purpose, when that reliance is reasonable under the circumstances. For example, a covered entity may rely on representations from the CDC that the protected health information requested by the CDC about all patients exposed to or suspected or confirmed to have COVID-19 is the minimum necessary for the public health purpose. In addition, internally, covered entities should continue to apply their role-based access policies to limit access to protected health information to only those workforce members who need it to carry out their duties.

**f. In an emergency, what sort of safeguards must be in place to protected patient information?**

Covered entities must continue to implement reasonable safeguards to protect patient information against intentional or unintentional impermissible uses and disclosures. Further, covered entities (and business associates) must apply the administrative, physical, and technical safeguards of the HIPAA Security Rule to electronic protected health information.

**g. Where can I find more information?**

For more information on HIPAA during times of an emergency and subsequent response, please visit [this HHS Fact Sheet](#).

**h. In summary, what sort of technologies are allowed?**

Technologies that MAY be used that do not meet HIPPA requirements:

- Apple FaceTime
- Facebook Messenger video chat
- Google Hangouts video
- Skype

HIPPA compliant providers:

- Skype for Business
- Updox
- VSee
- Zoom for Healthcare
- Doxy.me

- Google G Suite Hangouts Meet

You can NOT use:

- Facebook Live
- Twitch
- TikTok
- Instagram

## CPT Codes and Billing

### **1. Are there any new CPT Codes for SARS-CoV-2?**

Yes. The American Medical Association announced that the CPT Editorial Panel approved a new addition to the Current Procedural Terminology (CPT) code set related to the novel coronavirus (SARS-CoV-2). For reference, the new Category I CPT code and short, medium and full descriptors are as follows:

- 87635 SARS-COV-2 COVID-19 AMP PRB (short)
- 87635 IADNA SARS-COV-2 COVID-19 AMPLIFIED PROBE TQ M (medium)
- 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 (full)

The code set is immediately effective and ready for use. Providers will need to manually upload this code descriptor into an EHR system.

Further information can be found on the [CPT Assistant Fact Sheet](#).

### **2. What is CMS' coding guidance for laboratory testing of COVID-19 and what are the rates for testing?**

CMS is working closely with the Centers for Disease Control and Prevention (CDC) to establish the appropriate coding practices related to COVID-19. CMS developed the first Healthcare Common Procedure Coding System (HCPCS) code (U0001) to pay for claims and track testing for COVID-19. This code is used specifically for CDC testing laboratories to test patients for SARS-CoV-2. CMS has since added a second HCPCS billing code (U0002) which allows laboratories to bill for non-CDC lab tests for SARS-CoV-2/2019-nCoV (COVID-19).

Medicare claims processing systems will be able to accept these codes starting on April 1, 2020, for dates of service on or after February 4, 2020. These codes serve to increase more testing and improve tracking.

Because these HCPCS codes allow those labs conducting the tests to bill for the specific test instead of using an unspecified code, a descriptor is not required for HIPAA compliance.

On February 6, 2020, CMS also gave Clinical Laboratory Improvement Amendments (CLIA)-certified laboratories information about how they can test for SARS-CoV-2. To read more about those efforts, visit: [here](#).

CMS's 12 local administrative contractors process and pay the fee-for-service Medicare claims for each of their respective jurisdictions. The contractors use a variety of methodologies to price new tests that will be paid at the local level, until a national price is established through CMS's annual laboratory meeting process that includes the opportunity for public feedback. CMS is actively working with the contractors in this process and will provide information in separate guidance once it is available.

### **3. Are there any ICD-10 Coding Guidance for Covid-19?**

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, Other coronavirus as the cause of diseases classified elsewhere. Bronchitis not otherwise specified (NOS) due to the COVID-19 should be coded using code J40, Bronchitis, not specified as acute or chronic; along with code B97.29, Other coronavirus as the cause of diseases classified elsewhere.

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, this should be assigned with code J22, Unspecified acute lower respiratory infection, with code B97.29, Other coronavirus as the cause of diseases classified elsewhere. 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, Other coronavirus as the cause of diseases classified elsewhere.

ARDS - Acute respiratory distress syndrome (ARDS) may develop in with the COVID-19, according to the Interim Clinical Guidance for Management of Patients with Confirmed 2019 Novel Coronavirus (COVID-19) Infection. Cases with ARDS due to COVID-19 should be assigned the codes J80, Acute respiratory distress syndrome, and B97.29, Other coronavirus as the cause of diseases classified elsewhere.

Exposure to COVID-19 - For cases where there is a concern about a possible exposure to COVID-19, but this is ruled out after evaluation, it would be appropriate to assign the 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, it would be appropriate to assign the code Z20.828, Contact with and (suspected) exposure to other viral communicable diseases.

#### 4. What are the codes for a patient with the signs and symptoms?

For patients presenting with any signs/symptoms (such as fever, etc.) and where 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

Note: Diagnosis code B34.2, Coronavirus infection, unspecified, would in general not be appropriate for the COVID-19, because the cases have universally been respiratory in nature, so the site would not be “unspecified.”

If the provider documents “suspected”, “possible” or “probable” COVID-19, do not assign code B97.29. Assign a code(s) explaining the reason for encounter (such as fever, or Z20.828).<sup>1</sup>

### Ohio Specific Information

The Ohio Department of Health provides a comprehensive website with real-time updates on public health orders, Executive Orders from Governor DeWine, and other general safety tips and information. [Ohio-COVID-19](#).

Additional resources for local health departments and providers can be found [here](#). The Health Policy Institute of Ohio provides a great resource with a compilation of materials from ODH, CDC, OMHAS, OHA, WHO, and Johns Hopkins Resource Center, which can be found [here](#).

### Federal Information

General information regarding the coronavirus can be found at the [CDC website](#). CMS also provides a portal of information which can be found [here](#).

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<sup>1</sup> This coding guidance has been developed by CDC and approved by the four organizations that make up the Cooperating Parties: the National Center for Health Statistics, the American Health Information Management Association, the American Hospital Association, and the Centers for Medicare & Medicaid Services. 31

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