AQREVA
Medical Billing & Consulting

"In nothing do men more nearly approach the gods than in giving health to men." ~~ Cicero

Client Memo
April 2020

NEWS Update

Advance Payment Program Expanded

CMS expands Advance Payment Program during COVID-19 health emergency.

CMS has announced an expansion of its existing accelerated Advance Payment Program (APP), making the program available nationwide for Medicare participating health providers and suppliers.

To qualify for the accelerated or advance payments, the provider must meet the following requirements:

- **Have billed Medicare for claims within 180 days immediately prior to the date of request;**
- **Not be in bankruptcy;**
- **Not be under any active medical review or program integrity investigation; and**
- **Not have any outstanding delinquent Medicare overpayments.**

Qualified providers and suppliers can request up to 100% of the Medicare payment amount for a three-month period. Requests must be submitted to the appropriate Medicare Administrative Contractor (MAC).

Each MAC will review and issue payment within seven calendar days of receiving the request.

Repayment has been extended to 120 days after the payment has been issued for most providers and suppliers.

- Claims will continue to be processed and paid as usual during the 120-day period.
- After the 120 days, the recoupment process automatically starts and every claim submitted will be offset to repay the advanced payment.

A fact sheet on the APP process and how to submit a request can be found at: www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf.

As per the instructions on the fact sheet, a Request for Advance Payment form, page 2, must be completed to begin the process. **State "COVID-19" in the reason for hardship section.**

Page 3, the Request Certification, must be completed before the MAC can finalize the request.

For providers and suppliers in Jurisdiction F (Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, and Wyoming), the APP request form can be found on the Noridian Medicare website under Emergencies and Disasters -- Covid 19: https://med.noridianmedicare.com/documents/10542/72941/Advance+Payment+Request+Form?version=1.3

CMS has also established COVID-19 hotlines at each MAC that are operational Monday – Friday to assist with APP requests.

Jurisdiction E & Jurisdiction F (AK, AZ, CA, HI, ID, MT, ND, NV, OR, SD, UT, WA, WY, AS, GU, MP). DME A & D (CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI, VT, AK, AZ, CA, HI, ID, IA, KS, MO, MT, NE, NV, ND, OR,SD, UT, WA, WY, AS, GU, MP) providers and suppliers can call:

The toll-free Hotline Telephone Number:
1-866-575-4067
Hours of Operation: 8:00 am – 6:00 pm CT

MACS for providers and suppliers in other states are listed in the APP fact sheet.

MGMA announced on March 30, 2020, that this was a step in the right direction but is advocating that the Administration make available funding that is not subject to repayment or recoupment.

Temporary Suspension of CMS Sequestration

In accordance with the CARES Act signed into law on March 27, 2020, CMS has implemented a temporary suspension of Medicare sequestration, beginning May 1, 2020, and ending on December 31, 2020.

How to Start Doing Telemedicine Now

Dr Neal Sikka informs physicians that they won't have to deal with complicated technology to use telemedicine in his March 25, 2020, commentary for *Medscape Business of Medicine.*

The world has changed for telemedicine, Dr Sikka writes.

A couple of months ago, only a very small percentage of physicians used video visits. Some were not interested, while others were apprehensive about navigating the complicated regulatory landscape.

Restrictive laws limited telemedicine use to rural areas, specific locations where the patient could be during the visit, and to patients located in states in which the physician had an active medical license.

The COVID-19 crisis has changed everything. Through an emergency declaration made March 17, 2020, CMS will pay providers to care for Medicare beneficiaries for office, hospital, and other visits furnished via telehealth anywhere in the country, including a patient's place of residence. These services can also be provided in nursing homes, hospital outpatient departments, and other settings, and across state lines.

HHS Office for Civil Rights (OCR) will also exercise enforcement discretion and waive penalties for HIPAA violations against healthcare providers who serve patients in good faith through everyday communication technologies such as Zoom, Doxy.me, Skype, and FaceTime, among others.

To participate in telemedicine on the most basic level, doctors only need a computer, a camera, a headset with microphone, and a secure platform that can manage telemedicine information, Dr Sikka explains.

The hardware component of telemedicine is becoming less critical. You need access to your EHR and access to video. This might be a single desktop or laptop with multiple screens or it might be two devices—one device for the EHR and one for video, such as a laptop, tablet, or mobile phone.

Many EHR systems, including Allscripts, Cerner, and Epic, provide basic telemedicine functions. However, platforms that are part of EHR systems are usually not as robust as self-standing telemedicine software purchased separately.

Self-standing platforms may provide such features as appointment scheduling; managing upcoming patients waiting their turn; e-prescribing; sharing lab and imaging results; and controlling devices on the patient's end, such as a remote camera, a digital stethoscope, and other scopes.

The downside of self-standing platforms is that they may not integrate with your EHR system or your patient portal, meaning that patient records have to be managed separately, and patients may need to download a second app to make a connection.

In these cases, you can manage your end of the transmission by setting up two screens for the telemedicine visit: one screen for the telemedicine connection and the other to enter documentation into your EHR.

Some doctors like to use basic videoconferencing tools, such as Skype, FaceTime, and Google Hangouts, for telemedicine. These modalities are free and easy to use. Some of these platforms, while easy to use, are not designed for healthcare and may reveal your personal email address or phone number.

The technology for telemedicine is very simple: a secure telemedicine platform that creates the telemedicine connection, concludes Dr Sikka. Many EHR systems provide a simple telemedicine platform. Independent vendors provide platforms that are usually more robust, but they may not integrate with your medical records.

To be secure, telemedicine data needs to be encrypted, and it is a good idea to obtain a BAA from the vendor to comply with HIPAA. Patient verification software is not necessary if telemedicine is limited to existing patients using the practice's secure patient portal.

AMA Offers Guidelines for Telehealth Reimbursement During the Pandemic – Eric Wicklund, *mHealth Intelligence,* March 27, 2020

The AMA has released a guide to help providers get paid for their telehealth services during the COVID-19 pandemic.

The new document outlines 11 different scenarios for treating patients, and the appropriate CPT codes to qualify for Medicare reimbursement. All take into account the emergency actions announced earlier this month by CMS. The guide is available at: https://www.ama-assn.org/system/files/2020-03/covid-19-coding-advice.pdf

Billing for Telehealth Visits

CMS is suspending many of the requirements attached to telehealth during this public health emergency. The originating site requirement no longer applies. Telehealth can be conducted at any health care facility or in the patient's home.

CMS will also not enforce the anti-kickback regulations during this time if providers opt to waive or reduce copays or other cost-sharing amounts for telehealth services. This does not apply to Virtual Check-In Visits or E-Visits.

It is important to understand what the different types of Telehealth visits are, with Telemedicine being only one of them. Here is a quick summary of each.

1. Telemedicine – audio and video/visual communication technology (the provider and patient can see each other) used for direct communication with a patient for office and hospital visits, and other services that would generally occur face-to-face in person. Must be patient initiated.

2. Virtual Check-Ins – BRIEF 5-10 minute telephone communication, initiated by the patient. Can only be used for established patients who have not had a medical visit related to the call within the previous 7 days.

3. Timed Telephone Visits – timed telephone evaluation visits, initiated by the patients, to communicate with their doctors, or other qualified health professional normally allowed to charge an E&M visit, to avoid unnecessary trips to the office. Can only be used for established patients who have not had a medical visit related to the call within the previous 7 days and the call does not lead to a medical visit within the next 24 hours or soonest available appointment.

4. E-Visits – patient-initiated online evaluation and management services conducted via a patient portal for Medicare Part B beneficiaries. Communication can occur over a 7 day period.

How to bill for Telemedicine, Virtual Check-Ins/Telephone Visits and E-Visits

The information presented below is in keeping with changes made on March 30, 2020, with the effective date pushed back to March 1, 2020 for all telehealth services. In order to deliver telehealth services, a provider must still be a Medicare 'qualified provider."

Telemedicine Visits:

Claims for professional services should be submitted using the appropriate CPT code (E/M or other acceptable office visit code) and the modifier 95, GT or UD depending on the patient's insurance plan.

95 modifier: Synchronous telemedicine service rendered via a real-time interactive audio-visual/ video telecommunications system.
GT modifier: face-to-face encounter utilizing interactive audio-visual communication
GO modifier: Telehealth services for the diagnosis, evaluation or treatment of symptoms of an acute stroke
UD modifier: Medicaid only
GQ modifier: Cigna only

Reminder: since providers will not be able to do a complete physical exam, they should select their levels based on time to determine the correct E&M code.

Telemedicine - Audio/Visual communication	CPT Code	Modifier	POS
Medicare	E&M/well checks, etc	95	11
AHCCCS	E&M/well checks, etc	UD	12
Cigna	E&M/well checks, etc	GQ	11
United Healthcare	E&M/well checks, etc	95 or GT	11
Blue Cross Blue Shield	E&M/well checks, etc	95 or GT	11
Aetna	E&M/well checks, etc	95 or GT	11
Humana	E&M/well checks, etc	95 or GT	11
Tricare	E&M/well checks, etc	95	11

Medicaid is also requiring the use of specified modifiers related to services provided as a result of, or related to, the COVID-19 emergency.

"CR" Modifier - Catastrophe/Disaster: used on all claims for services provided as a result of, or related to, the national emergency declaration of March 13, 2020 related to the COVID-19 outbreak.

UD Modifier: used when billing the applicable CPT or HCPCS code to designate telephonic service.

Virtual Check-In/Telephone Visits:

For brief 5-10 min telephone call:
G2012: Communication via telephone or other modalities
G2010: Remote evaluation of recorded video and/or images submitted by a patient

For telephone evaluation services by provider:
99441: Telephone E/M service 5-10minutes of medical discussion
99442: 11-20 minutes of medical discussion
99443: 21-30 minutes of medical discussion

If the call lasts longer than 30 minutes, you can use more than one of the above codes.

Telephone evaluation by a non-physician provider:
98966: telephone services by a qualified non-physician provider, 5-10 minutes
98967: 11-20 minutes
98968: 21-30 minutes

If the call lasts longer than 30 minutes, you can use more than one of the above codes.

Virtual Check-in Visits - telephone only	CPT Code	Modifier	POS
Medicare - BRIEF 5-10 min communicating via telephone	G2012	95	11
Medicare- evaluation of video or image submitted by patient	G2010	95	11
Cigna Insurance	G2012 5-10 minutes	95	11
Timed telephone evaluation services by physicians	99441 5-10 minutes	95	11
	99442 11-20 minutes	95	11
	99443 21-30 minutes	95	11
Timed telephone evaluation services by non-physicians	98966 5-10 minutes	95	11
	98967 11-20 minutes	95	11
	98968 21-30 minutes	95	11

E-Visits: - communication through any digital method, including patient portals

Bill using codes 99421-99423 (commercial) and HCPCS codes G2061-G2063 (Medicare) as applicable:
G2061 or 99421 – 5 – 10 minutes
G2062 or 99422 – 11-20 minutes
G2063 or 99423 – 21 or more minutes

E-Visits - Online digital communication	CPT Code	Modifier	POS
Providers, NPs, PA's	99421 5-10 minutes		11
	99422 11-20 minutes		11
	99423 21 + minutes		11
Medicare qualified non-physician providers	G2061 5-10 minutes		11
	G2062 11-20 minutes		11
	G2063 21-30 minutes		11
Commercial qualified non-physician providers	98970 5-10 minutes		11
	98971 11-20 minutes		11
	98972 21 + minutes		11

**IMPORTANT: Clinicians who cannot independently bill for E&M visits (i.e. physical therapists, occupational therapists, psychologists, etc) can also provide e-visits using the codes above.

Telemedicine Reimbursement

Telehealth using audio and visual technology such as doxy.me	Medicare Allowable In Office
99202	$75.16
99203	$106.55
99204	$163.09
99205	$206.19
99212	$44.86
99213	$74.21
99214	$107.78
99215	$144.89

Virtual Checkins - telephone	Medicare Allowable
G2010	$12.00
G2012	$14.49
	AHCCCS Allowable
99441	$11.02
99442	$21.46
99443	$31.90
Non Physicians	
98966	$11.97
98967	$23.32
98968	$34.66
E Visits - via patient portal	Medicare
99421	$15.18
99422	$30.32
99423	$49.00
Non Physician	
G2061	$12.10
G2062	$21.35
G2063	$33.45

COVID-19 Diagnosis Coding Update

Beginning April 1, 2020, healthcare professionals need to use:

U07.1 - confirmed COVID-19 case
U07.2 – probable, suspected COVID-19

B97.29 (Other coronavirus as the cause of diseases) is no longer to be used after April 1, 2020.

COVID-19 is affecting all aspects of healthcare and has even led the CDC to take the unprecedented step of introducing a new code, outside of its usual time cycle, which negates the code introduced just weeks ago, reports Betsy Nicoletti in her March 30, 2020, article "Coding for Coronavirus: NEW Guidance Replaces the Rule of 1 Month Ago," for *Medscape Business of Medicine.*

The first ICD-10 direction is to use an additional code to identify pneumonia or other manifestations. That tells the practice to use U07.1 as the first listed diagnosis for a patient with confirmed COVID-19. Then, add an additional diagnosis for pneumonia or condition, or symptom.

Here are some examples:

Pneumonia, confirmed as due to COVID-19
U07.1 COVID-19
J12.89: other viral pneumonia

Acute bronchitis, confirmed as due to COVID-19
U07.1 COVID-19
J20.8: acute bronchitis due to other specified organisms

There are also three "Excludes1" notes. This designation means "not coded here." The code should never be used at the same time as the code listed above it. That is, do not use U07.1 with:

- Coronavirus infection, unspecified (B34.2)
- Coronavirus as the cause of diseases classified to other chapters (B97.2-)
- Severe acute respiratory syndrome [SARS], unspecified (J12.81)

The availability of testing for COVID-19 is increasing in some areas. If the physician has not confirmed the condition as being due to this new coronavirus, do not use U07.1. Use the condition (pneumonia, bronchitis, or symptom, or symptoms such as cough, fever, shortness of breath) in the first position.

If the patient has been exposed to someone who is confirmed to have had COVID-19, **use Z20.828:** contact with and (suspected) exposure to other viral communicable diseases.

If the COVID-19 virus is suspected but testing does not confirm that the patient has the disease, use the confirmed diagnosis such as bronchitis, or assignment symptom such as cough, and add Z03.818 (encounter for observation for suspected exposure to other biological agents ruled out).

OCR Clarifies HIPAA Liability on Tele-health Use During COVID-19 – Jessica Davis, *Health IT Security*, March 23, 2020

The Department of Health and Human Services' Office for Civil Rights announced it would not impose penalties for noncompliance with HIPAA regulations against providers leveraging telehealth platforms that may not comply with the regulations, following the Trump Administration's expansion of telehealth services and HHS' waiver of some HIPAA sanctions.

The OCR notification of enforcement discretion applies to all HIPAA-covered healthcare providers that use telehealth services during the emergency. Excerpts from Ms. Davis's article that summarize key points are presented below.

- Providers are told to use a "non-public facing" remote communication, which only allows intended parties to participate as a default. Some examples are Google Hangouts video, Whatsapp video chat, or Skype. (Zoom is another one)

- For texting applications, providers can use platforms which allow only an individual and the person with whom the individual is communicating to see what is transmitted.

- These platforms also have individual user accounts and credentials, which will help providers limit access and verify the participants.

- Public-facing products such as TikTok, Facebook Live, Twitch, or a chat room like Slack are not acceptable forms of remote communication for telehealth because they are designed to be open to the public or allow wide or indiscriminate access to the communication.

- OCR will not impose a penalty on the provider if electronic protected health information is intercepted during the telehealth transmission. OCR will consider all facts and circumstances of the good faith provision, and if the provider follows appli-

cable OCR guidance, he or she will not face HIPAA penalties.

- Providers are expected to conduct telehealth in private settings, like in an office or clinic. OCR stressed that patients should not receive these services in a public or semi-public setting, "absent patient consent or exigent circumstances."

- If telehealth cannot be provided in a private setting, covered healthcare providers should continue to implement reasonable HIPAA safe-guards, such as lowering voices, not using speakerphone, or recommending that the patient move to a reasonable distance from others.

The notice also identified key areas that would be considered bad faith use, some of which are:

- Conducting or furtherance of a criminal act, such as fraud, identity theft, and intentional invasion of privacy.

- Further uses or disclosures of patient data transmitted during a telehealth communication that are prohibited by the HIPAA Privacy Rule (i.e., sale of the data, or use of the data for marketing without authorization).

- Violations of state licensing laws or professional ethical standards that result in disciplinary actions related to the treatment offered or provided via telehealth (i.e., based on documented findings of a healthcare licensing or professional ethics board).

- Use of public-facing remote communication products, such as TikTok, Facebook Live, Twitch, or a chat room like Slack, which OCR identified as unacceptable forms of remote communication for telehealth.

However, the enforcement discretion does not apply to 42 CFR Part 2, the regulation regarding how the data of substance use disorder patients are shared. The Substance Abuse and Mental Health Services Administration (SAMHSA) released its own guidance in light of the pandemic.

OCR reminded covered entities that although it will not be enforcing penalties for HIPAA noncompliance around telehealth, HIPAA rules will still be applied and enforced for all other areas outside of telehealth use.

The current OCR enforcement discretion does not currently have an end date.

ZOOM to Focus on Privacy and Security

Zoom, the videoconferencing platform, announced that it was shifting its engineering resources for the next 90 days to focus on privacy and security issues, in light of recent cybersecurity concerns that have emerged during the Coronavirus pandemic, writes Jessica Davis for *Health IT Security*, April 2, 2020.

The Office for Civil Rights has lifted penalties for HIPAA noncompliance around expanded telehealth use during the crisis. Zoom was listed as an acceptable platform for this use, which means providers can use the platform for remote care or consultations.

The news follows the launch of an inquiry into the platform by Sen. Richard Blumenthal, D-Connecticut, who sent the videoconferencing service vendor a letter to gain insight into their privacy and security policies and technologies after reports showed several privacy issues were putting user data at risk.

Zoom has since released fixes to the most recently discovered vulnerabilities.

In light of the rapid increase of use and these concerns, Zoom has been offering both free training sessions and tutorials to ensure users can better understand the best and safest ways to use the platform, including guidance on virtual classrooms.

Zoom has also since updated its privacy policy to be more transparent. For the next 90 days, Zoom will be conducting a comprehensive reviews with assistance from third-party experts and users to better understand the security needs of new consumer use cases, in addition to preparing a transparency report outlining requests for data, records, or content and enhancing its current bug bounty program.

Telehealth Platforms

If providers do not want to use their personal cell phones and have patients in possession of their phone numbers, telemedicine software that enables medical providers to diagnose or treat patients remotely using secure telecommunications tools like video chats, phone, email, etc. is available.

A free, and simple platform called **doxy.me** is available to providers wanting a simple and easy tool. Please go to https://doxy.me for more information and instructional videos.

Covered Entities May Disclose COVID-19-Related PHI – Maria G Danaher, *National Law Re-view*, April 3, 2020

Healthcare entities are facing a growing number of challenges related to the virus SARS-CoV-2 and the disease caused by that virus, COVID-19.

Among the primary concerns is whether a specific health-care entity is covered by HIPAA; and if so, how to avoid violating that rule when sharing names or other identifying information of individuals infected with or exposed to the virus.

The U.S. Department of Health and Human Services (HHS) has issued a summary of the circumstances in which HIPAA's Privacy Rule allows a covered entity to share that information with law enforcement, paramedics, other first responders, and public health authorities, without an individual's explicit authorization.

The Privacy Rule applies to "covered entities," which includes health care providers, health plans, and health care clearing houses.

The HHS clarified that if, in fact, the entity at issue falls within the definition of "covered entity," it is permitted to disclose the PHI of an individual infected with, *or exposed to,* COVID-19, with "law enforcement, paramedics, other first responders, and public health authorities" without explicit authorization from the affected individual, in certain circumstances.

According to the HHS, those circumstances include:

- When the disclosure is needed to provide treatment
- When the notification is required by law (i.e., reporting cases of infectious diseases to public health officials)
- To notify a public health authority in order to prevent or control the spread of disease
- When first responders may be at risk of infection
- When responding to a request for PHI by a correctional institution/law enforcement official having lawful custody of an inmate or other individual

Generally, a covered entity must make reasonable efforts to limit the amount of information disclosed to that which is the "minimum necessary" to accomplish the purpose for the disclosure.

MIPS Change Due to COVID-19

CMS to Apply MIPS Extreme and Uncontrollable Circumstances Policy In Response to COVID-19

CMS is offering multiple flexibilities to provide relief to clinicians responding to the COVID-19 pandemic. In addition to extending the 2019 MIPS data submission deadline to April 30, 2020 at 8 PM ET, the MIPS automatic Extreme and Uncontrollable Circumstances policy will apply to MIPS eligible clinicians who do not submit their MIPS data by the April 30 deadline.

The automatic Extreme and Uncontrollable Circumstances policy does not apply to group participants.

If you are a MIPS eligible clinician and do not submit any MIPS data by April 30, 2020, you won't need to take any additional action to qualify for the automatic Extreme and Uncontrollable Circumstances policy. You will be auto-matically identified and will receive a neutral payment adjustment for the 2021 MIPS payment year.

Please note, CMS has updated the QPP Participation Status Tool so eligible clinicians can see if the policy has been automatically applied.

Additional 2019 Relief Measure

CMS is also reopening the MIPS extreme and uncontrollable circumstances application for individuals, groups, and virtual groups.

Who should submit an application?

- Individual clinicians who started, but are unable to complete, their data submission;
- Groups that started, but are unable to complete, their data submission; and
- Virtual groups that are unable to start or complete their data submission.

An application submitted between April 3 and April 30, 2020, citing COVID-19, will override any previous data submission.

For more information, please see the Quality Payment Program COVID-19 Response Fact Sheet.

https://qpp.cms.gov/about/resource-library

Medicare News

COVID-19 Regulatory Changes, March 31, 2020

At President Trump's direction, CMS issued an unprecedented array of temporary regulatory waivers and new rules to equip the American health care system with maximum flexibility to respond to the COVID-19 pandemic.

Put Patients over Paperwork is one of the temporary waivers. CMS is temporarily eliminating paperwork requirements and allowing clinicians to spend more time with patients. Medicare will now cover respiratory-related devices and equipment for any medical reason determined by clinicians so that patients can get the care they need; previously Medicare only covered them under certain circumstances.

CMS is providing temporary relief from many audit and reporting requirements so that providers, health care facilities, Medicare Advantage health plans, Medicare Part D prescription drug plans, and states can focus on providing needed care to Medicare and Medicaid beneficiaries affected by COVID-19.

Long-Term Care Nursing Homes Telehealth and Telemedicine Tool Kit

CMS has issued an electronic toolkit regarding telehealth and telemedicine for Long Term Care Nursing Home Facilities.

In response to the need to limit the spread of community COVID-19, CMS has broadened access to Medicare telehealth services so that beneficiaries can receive a wider range of services from their doctors without having to travel to a healthcare facility.

This document contains electronic links to reliable sources of information regarding telehealth and telemedicine, including the significant changes made by CMS over the last week in response to the National Health Emergency.

Most of the information is directed towards providers who may want to establish a permanent telemedicine program, but there is information here that will help in the temporary deployment of a telemedicine program as well.

There are specific documents identified that will be useful in choosing telemedicine vendors, equipment, and software, initiating a telemedicine program, monitoring patients remotely, and developing documentation tools.

There is also information that will be useful for providers who intend to care for patients through electronic virtual services that may be temporarily used during the COVID-19 pandemic.

The Tool Kit is available at:
https://www.cms.gov/files/document/covid-19-nursing-home-telehealth-toolkit.pdf

*** Disclaimer: Information contained herein was current at the time of publication; however, the COVID-19 emergency is a fluid situation. Updates and new information are coming in constantly. We apologize ahead of time for any inaccuracies that may occur because of this.***

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