



Keeping up with COVID-19

Webinar Series

Q&A

April 16, 2020

The CARES Act Impact on Health Care Funding and Programs

Post Webinar Q&A

Thank you for your questions. nThrive has addressed many of these issues in the coding updates and protocols found on the new **nThrive COVID-19 Coronavirus** www.nthrive.com/covid19 **microsite**. This site includes a link to our webinars, summary guidelines for CMS updates, quick reference guides, videos, summary overviews of nThrive protocols and business continuity plans, access to our thought leadership webinars and an overview of the business continuity and business recovery solutions to help our clients during this challenging time.

We are receiving information from CMS daily which also reflects frequent changes in guidance as they too work to operationalize the provisions in the CARES Act. There is also an Interim Final Rule (IFR) that will soon be published that is impacting the guidance received from CMS. nThrive is working diligently to share this information and update previous information through these coding updates on the nThrive portal. We recommend accessing these documents for details on how to report these services.

Many participants have asked the same or very similar questions, and we have grouped these and provided a singular response, following.

[Click below for more info](#)

CARES Act Funding

Claim Codes and Modifiers

Telehealth for Hospital and Therapy Services

Telehealth for Physician Services

Additional Questions

CMS FAQ

nThrive also directs participants to the CMS Frequently Asked Question (FAQ) page that is frequently updated for answers to many common questions. It may be found at:

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

CARES Act Funding

Application for funds made available by the CARES Act:

- ✓ The initial launch of the \$100 billion will be distributed according to 2019 Medicare FFS expenditures.
- ✓ There has been no guidance to-date about the remaining \$70 billion and how much may be requested.
- ✓ Both CARES and agency guidance state that you can apply for funds through the Department of Health and Human Services Office of the Assistant Secretary for Preparedness.
- ✓ During the emergency period, the legislation provides a 20% add-on to the DRG rate for patients with COVID-19. This add-on will apply to patients treated at rural and urban inpatient prospective payment system (IPPS) hospitals.
 - Regarding the 20% add-on to inpatient COVID-19 cases, guidance was issued yesterday by CMS, and nThrive will have that update in the May 13, 2020 release of Contract Manager.
 - CMS has not released information indicating that a higher APC payment will be received for treating COVID-19 patients in the ED or other outpatient setting.
- ✓ For providers that do not qualify for the distribution of funds under the CARES Act there is relief under the Main Street Lending Program for businesses with fewer than 10,000 employees.
- ✓ Funding is available by the Federal Communications Commission(FCC). The COVID-19 Telehealth Program will provide \$200 million in funding, appropriated by Congress as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, to help health care providers provide connected care services to patients at their homes or mobile locations in response to the novel Coronavirus 2019 disease (COVID-19) pandemic.

Use of and documentation of funds received under the CARES Act:

- ✓ The \$100 billion in CARES is meant to be distributed and spent by the end of December 31, 2020 and is designed to be spent by end of the calendar year to address immediate spending shortfalls caused by COVID19.
 - Documentation for it is detailed in the DHHS Terms and Conditions memo.

- The attestation form referenced in the memo does not appear to have been developed or provided at this time. nThrive recommends providers continue to monitor both DHHS and CMS COVID-19 websites.
- ✓ The \$27 billion is designed to be used through the end of FY 2024.
 - CMS has not provided direction on audit procedures or documentation regarding the programs it is administering.
- ✓ All funds under the CARES Act must be documented under the terms of the HHS Terms and Conditions memo. It provides:
 - Not later than 10 days after the end of each calendar quarter, any recipient that is an entity receiving more than \$150,000 total in funds under the Coronavirus Aid, Relief, and Economics Security Act (P.L. 116-136), the Coronavirus Preparedness and Response Supplemental Appropriations Act (P.L. 116-123), the Families First Coronavirus Response Act (P.L. 116-127), or any other Act primarily making appropriations for the coronavirus response and related activities, shall submit to the Secretary and the Pandemic Response Accountability Committee report.
 - This report shall contain:
 - » The total amount of funds received from HHS under one of the foregoing enumerated Acts.
 - » The amount of funds received that were expended or obligated for reach project or activity.
 - » A detailed list of all projects or activities for which large covered funds were expended or obligated, including:
 - The name and description of the project or activity, and the estimated number of jobs created or retained by the project or activity, where applicable.
 - Detailed information on any level of sub-contracts or subgrants awarded by the covered recipient or its subcontractors or subgrantees, to include the data elements required to comply with the Federal Funding Accountability and Transparency Act of 2006 allowing aggregate reporting on awards below \$50,000 or to individuals, as prescribed by the Director of the Office of Management and Budget.



Repayment of funds received:

- ✓ CMS has extended the repayment of these accelerated/advance payments to begin 120 days after the date of issuance of the payment.
- ✓ The repayment timeline is broken out by provider type:
 - Inpatient acute care hospitals, children’s hospitals, certain cancer hospitals, and Critical Access Hospitals (CAH) have up to one year from the date the accelerated payment was made to repay the balance.
 - All other Part A providers and Part B suppliers will have 210 days from the date of the accelerated or advance payment was made to repay the balance.
 - The provider/supplier can continue to submit claims as usual after the issuance of the accelerated or advance payment; however, recoupment will not begin for 120 days.
- Providers/ suppliers will receive full payments for their claims during the 120-day delay period.
 - » At the end of the 120-day period, the recoupment process will begin and every claim submitted by the provider/supplier will be offset from the new claims to repay the accelerated/advanced payment.
 - » Instead of receiving payment for newly submitted claims, the provider’s/supplier’s outstanding accelerated/advance payment balance is reduced by the claim payment amount.
 - » This process is automatic. ■

Claim Codes and Modifiers

As of this date, the following guidance is applicable:

Modifier CS

April 7, 2020 CMS released an MLN Special Edition that included an article that, according to the title, addressed the waiving of copays and deductibles. On the surface, this may not have captured the interest of those preparing claims data. However, the article directs providers to utilize an additional modifier to indicate that the line-item service was related to the assessment for, or diagnosis of, COVID-19 whether it results in testing or not.

This change is retroactive to March 18, 2020 and continues through the end of the PHE. These services might have been provided face-to-face, by telehealth or by the Lab. Regardless, Modifier *CS*, *Cost Sharing Waived*, must be applied.

Providers that have already submitted claims on or after March 18, 2020 must take additional action:

- For professional claims, physicians and practitioners who did not initially submit claims with the Modifier CS must notify their Medicare Administrative Contractor (MAC) and request to resubmit applicable claims with dates of service on or after 3/18/2020 with the Modifier CS to get 100% payment.
- For institutional claims, providers, including hospitals, CAHs, RHCs, and FQHCs, who did not initially submit claims with the Modifier CS must resubmit applicable claims submitted on or after 3/18/2020, with the Modifier CS to visit lines to get 100% payment.

Modifier CS is to be applied in addition to any other modifiers or condition codes that may also be required.

Modifier CR

Modifier CR, *catastrophe/disaster related*, is used in relation to Part B items and services for **both institutional and non-institutional billing**. Non-institutional billing, i.e., claims submitted by “physicians and other suppliers,” are submitted either on a professional paper claim form CMS-1500 or in the electronic format ANSI ASC X12 837P or – for pharmacies – in the NCPDP format.

Modifier CR is historically considered no longer discretionary but is mandatory for applicable HCPCS codes on any claim for which Medicare Part B payment is conditioned **directly or indirectly** on the presence of a “formal waiver.” However, late Friday, April 3, 2020 CMS released a corrective bulletin indicating that Modifier CR is **not** to be used on 1500 professional claims for telehealth services.¹ Rather CMS states, professional providers “should report the place of service equal to what it would have been had the service been furnished in-person; and Modifier 95, indicating that the service rendered was actually performed via telehealth.”

April 3, 2020 CMS released a corrective bulletin indicating that professional providers “should not report Place of Service code 02 but report the place of service equal to what it would have been had the service been furnished in-person.” (CMS Special Edition Bulletin, April 3, 2020)



Condition Code DR

Condition code DR, *disaster related*, requires it to be “used to identify claims that are or may be impacted by specific payer/health plan policies related to a national or regional disaster.”

Condition code DR is used only for institutional billing, i.e., claims submitted by providers on an institutional paper claim form CMS-1450/UB-04 or in the electronic format ANSI ASC X12 837I. Effective August 31, 2009, use of the DR condition code will be mandatory for any claim for which Medicare payment is conditioned **directly or indirectly** on the presence of a “formal waiver.”

The use of Condition Code DR and Modifier CR indicates not only that the item/service/claim was affected by the emergency/disaster, but also that the provider has met all of the requirements CMS has issued to Medicare contractors regarding the emergency/disaster.²

According to the Medicare Claims Manual, the “DR condition code is used at the claim level when all of the services/items billed on the claim are related to the emergency/disaster.”³

Additional details and examples can be found in the coding updates published on the [nThrive COVID-19 Coronavirus Portal](#). ■

Telehealth for Hospital and Therapy Services

nThrive has been monitoring the CMS Open-Door calls and CMS has indicated that further guidance for hospital outpatient services is imminent. We will share that information on our microsite as soon as it is available.

In general, CMS has expanded the list of telehealth services that may be provided. The full list may be found at <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>.

This added certain physical medicine codes typically provided by PT, OT and Speech Therapy. However, CMS did not add the therapists to the list of eligible distant site providers. This issue was brought up in various Open-Door Forum calls with CMS. They indicated they were working to resolve the issue and gave no objection to those listeners who inquired about, or stated that they were, rendering the services in order to benefit their patients and were holding claims until the issue was resolved.

Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) as telehealth services are not dependent upon a waiver. These services were already on the list of eligible telehealth services prior to the Public Health Emergency (PHE). The dietitians and nutritional health providers were also already on the list of acceptable distant site providers. Subsequently, these services that traditionally have been provided in a classroom can be converted to a telehealth mechanism that includes both audio and video capabilities. The same charge and HCPCS codes would be submitted as they were when the patient came to the classroom.

The remaining element for providing services on the eligible telehealth list by eligible distant site providers in outpatient hospital departments was how to convey the service is now being rendered via telehealth. As a modifier was not

available for facility claims for this purpose, nThrive initially recommended use of Revenue code 0780, *Telemedicine*. However, just this week CMS has held several Open-Door Forum calls where they answered participant questions. One such question was posed regarding hospital use of Modifier 95, *Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System*.

CMS responded that Modifier 95 may be used on an eligible facility telehealth claim to indicate that the service was provided as required using both audio and video capability.

The virtual and telephone services shown on the table below are not considered telehealth and therefore have other requirements of the electronic technology that may be used. During this week’s Open-Door Forum calls CMS indicated that providers could obtain consent from the patient for the physician practice to initiate any future contact for those services defined as “patient initiated.”

In addition, during the April 8, 2020 call CMS indicated that those services not currently covered or reported under OPPS will be updated in upcoming rate tables and that providers may need to hold claims until the systems are updated to process and pay these claims. See nThrive Quick Reference Guide: [Telehealth Facility Coding](#).

Finally, many hospital providers have asked if the telehealth visits rendered by physicians or extenders in hospital or health system owned practice settings are subject to split billing as they did the face-to-face visits.





To date, everything CMS has stated or published would indicate that this is not the case and only the professional component may be billed. However, on the Open-Door Forum call on Wednesday, April 8, 2020 this was brought up by several participants and the CMS members on the



call asked that the question be submitted in writing for further consideration.

In addition, HCPCS Q3014, *Telehealth originating site facility fee*, may not be reported by a facility unless the patient is present at the location.

nThrive will provide any future directives regarding this subject through the coding updates published on the [nThrive COVID-19 Coronavirus Portal](#). ■

TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE ^E	Patient Relationship with Qualified Nonphysician Health Care Professional
MEDICARE TELEHEALTH VISITS^A 	Diabetes Self-Management Training and Medical Nutrition Therapy.	Common telehealth services include: ✓ 97802 (Medical nutrition indiv init) ✓ 97803 (Medical nutrition indiv subsq) ✓ 97804 (Medical nutrition group) ✓ G0108 (Diab manage trn per indiv) ✓ G0109 (Diab manage trn group) ✓ G0270 (MNT subs tx for change dx)	For new ^B or established patients.
VIRTUAL CHECK-IN^D 	A brief (5-10 minutes) check in with a qualified nonphysician healthcare professional ^C via telephone or other approved telecommunications device to decide whether an office visit or service is needed, or a remote evaluation of recorded video and/or images submitted by an established patient.	✓ G2010 (remote evaluation of recorded video) ✓ G2012 (brief communication tech-based service)	For established patients.
E-VISITS^D 	A communication between a patient and a qualified nonphysician health care professional through an online patient portal.	Online assessment: ✓ G2061 (5-10 minutes) ✓ G2062 (11-20 minutes) ✓ G2063 (21+ minutes)	For established patients including up to 7 days cumulative time.
TELEPHONE ASSESSMENT & MANAGEMENT 	A communication between a patient and a qualified nonphysician health care professional using the telephone.	Telephone assessment and management: ✓ 98966 (5-10 minutes) ✓ 98967 (11-20 minutes) ✓ 98968 (21+ minutes)	For new or established patients.

Notes

- A Review state-specific Medicaid and third-party insurance plans to determine whether services are covered, and which codes are recognized.
- B To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.
- C Qualified nonphysician health care professionals are currently identified in Sections 1842(b)(18)(C) and 1834(m)(4)(E) of the Social Security Act. [physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, clinical psychologists, clinical social workers, and registered

dietitians or nutrition professionals]. With the implementation of the CARES Act, LCSWs, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists were included for virtual check-ins and e-visits; expect additional information regarding billing requirements for the therapies.

- D Providers may use popular *non-public facing* applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype. Current waivers allow this service for both new and established patients even though the codes are defined as established.

- E Services are reported on institutional claims: Report the appropriate CPT/HCPCS; Report Condition code DR, *disaster related*, on the claim (other than for DSMT/MNT) as these other services are provided under formal waiver; Report Modifier CR, *catastrophe/disaster related*, for any services directly related to COVID-19; report Modifier 95, *Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System*. Apply Modifier CS, *Cost Sharing Waived*, to services with DOS 3/18/20 through end of PHE related to assessment for or diagnosis of COVID-19 whether it results in testing or not.

Telehealth for Physician Services

Q. Question regarding virtual visit billing. If we perform a phone visit (no audio) on a new patient and bill a 99441-99443 code, and decide to see the patient in the office a month or so from now, are we restricted from billing a new patient E/M code when the patient comes in for the first physical visit?

A. According to a recent CPT Assistant article “the 3-year rule applies to any E/M service that differentiates a new patient versus an established patient in the code descriptor, including, but not limited to E/M codes for observation care, hospital inpatient care, and nursing facility care. A new patient is defined as a patient who has not received any professional services from the physician or physician group practice (same physician specialty and subspecialty) within the previous 3 years (eg, E/M services, surgical procedures or other face-to-face services). Solely for the purposes of distinguishing between new and established patients, “professional services” are those “face-to-face” services rendered by physicians and other qualified health care professionals (QHPs) who may report E/M services. An established patient is defined as a patient who has received professional services from the physician or a physician in the same group practice of the same specialty and subspecialty within the previous 3 years.”

(CPT Assistant, June 2019, Volume 29, Issue 6, page 14)

nThrive is not aware of specific CMS direction regarding this topic when telehealth and virtual visits are replacing in-person visits. These codes were initially limited to established patients where the medical history was known to the provider. If this code is reported vs an E/M under telehealth for a new patient because of the absence of video capabilities it would still be assumed that a complete medical history would be established before making medical decisions and authorizing treatment or prescriptions. When the patient does eventually present for a face-to-face visit they will be known to the practitioner.

If additional guidance is not made available in the interval between the virtual service and when practices are able to re-open, we recommend you contact your MAC for more specific guidance.

Q. How is the complexity of a telehealth session decided?

A. CMS has confirmed that code level selection for E/M codes 99201 - 99215 may be based on either medical decision making alone or time alone only when performed via telemedicine and during the public health emergency. Time requirements for E/M levels are published in CPT 2020. Time should be based upon the physician and does not include staff time. ■

Additional Questions

Q. Ultimately, will we have to document or prove how we spent the funds?

A. Yes, all funds under the CARES Act must be documented under the terms of the HHS Terms and Conditions memo. It provides: no later than 10 days after the end of each calendar quarter, any recipient that is an entity receiving more than \$150,000 total in funds under the Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136), the Coronavirus Preparedness and Response Supplemental Appropriations Act (P.L. 116-123), the Families First Coronavirus Response Act (P.L. 116-127), or any other Act primarily making appropriations for the coronavirus response and related activities, shall submit to the Secretary and the Pandemic Response Accountability Committee a report.

This report shall contain:

✓ The total amount of funds received from HHS under one of the foregoing enumerated Acts

- ✓ The amount of funds received that were expended or obligated for each project or activity
- ✓ A detailed list of all projects or activities for which large covered funds were expended or obligated, including:
 - The name and description of the project or activity
 - The estimated number of jobs created or retained by the project or activity, where applicable
 - Detailed information on any level of subcontracts or subgrants awarded by the covered recipient or its subcontractors or subgrantees, to include the data elements required to comply with the Federal Funding Accountability and Transparency Act of 2006, allowing aggregate reporting on awards below \$50,000 or to individuals, as prescribed by the Director of the Office of Management and Budget.



Q. How long do we have to use these funds?

A. The \$100 billion in CARES is meant to be distributed and spent by the end of December 31, 2020. The \$27 billion is designed to be used through the end of fiscal year 2024.

Q. What is the max amount that can be requested?

A. The initial tranche of the \$100 billion will be distributed according to 2019 Medicare FFS expenditures. There has been no guidance yet about the remaining \$70 billion and how much may be requested.

Q. Can you apply for funds or do you simply have to document why you are eligible if you happen to receive them?

A. Both CARES and agency guidance state that you can apply for funds through the Department of Health and Human Services Office of the Assistant Secretary for Preparedness.

Q. What was the name of that agency again, please?

A. CARES is being administered through Centers for Medicare & Medicaid Services (CMS) and by the Department of Health and Human Services Office of the Assistant Secretary for Preparedness.

Q. Was the stimulus payment of last Friday a onetime payment?

A. Possibly. Little guidance has been provided about how the next \$70 billion will be spent. Please monitor CMS.gov for further updates.

Q. When you indicated that the initial \$30 billion must be expended by the end of the fiscal year, do you mean by the US government fiscal year ending 9/30/2020 or the calendar year end 12/31/2020?

A. It is designed to be spent by end of calendar year – 12/31/2020 – to address immediate spending shortfalls caused by COVID-19.

Q. For the accelerated payment, can we repay Medicare in one payment at the end of 120 days if we are able to, instead of letting them have it recoup from our payments?

A. CMS has extended the repayment of these accelerated/advance payments to begin 120 days after the date of issuance of the payment. The repayment timeline is broken out by provider type. Inpatient acute care hospitals, children's hospitals, certain cancer hospitals, and Critical Access Hospitals (CAH) have up to one year from the date the accelerated payment was made to repay the balance. All other Part A providers and Part B suppliers will have 210 days from the date of the accelerated or advance payment was made to repay the balance.

The provider/supplier can continue to submit claims as usual after the issuance of the accelerated or advance payment; however, recoupment will not begin for 120 days. Providers and/or suppliers will receive full payments for their claims during the 120-day delay period. At the end of the 120-day period, the recoupment process will begin, and every claim submitted by the provider/supplier will be offset from the new claims to repay the accelerated/advanced payment. Thus, instead of receiving payment for newly submitted claims, the provider's/supplier's outstanding accelerated/advance payment balance is reduced by the claim payment amount. This process is automatic.

Q. Will a facility receive any additional funds for outpatient testing or treatment in the ER or is it only for inpatient DRGs?

A. CMS has not released information indicating that a higher APC payment will be received for treating COVID-19 patients in the ED or other outpatient setting.

Q. Where can guidance be found on exact mechanisms (software changes or other, etc.) that will implement the 120% of DRG enhancement for IPPS hospitals, for COVID-19+ admissions?

A. The nThrive website main page contains a link to a (new) COVID-19 microsite that includes updated summaries of our product plans. Regarding the 20% add-on to inpatient COVID-19 cases, guidance was issued yesterday (April 15, 2020) by CMS, and we will have that update in our May 13, 2020 release of Contract Management

Q. Any updates on telehealth reimbursement for hospital-based clinics - technical component?

A. All updates on telehealth reimbursement is provided on the CMS COVID-19 website.

Q. Do you know where we can locate definitions to the following: COVID-19 related testing – COVID-19 related treatment – Waiver for Cost Sharing?

A. This is not in the CARES Act.

Q. How should you document use of funds if you are accessing multiple programs, e.g. SBA PPA, funds through the FI/MAC Advanced Funding and funds under the Provider Relief Program (the 1/16th program)?

A. See *guidance in question/answer 1* regarding documentation of the \$100 Billion. Documentation for it is detailed in the DHHS Terms and Conditions memo as provided above. CMS has not provided direction on audit procedures or documentation regarding the programs it is administering.



Q. In the context of the APP payments, I've read, "some providers covered under the CARES act will not start seeing the recoupments through the claims adjustments until 365 days after the payment received, where all others, the recoupment will start at day 121 after the payment is received". My question is, how do I know if I'm "covered under the CARES act?" My hospital received a stimulus, should I assume that means I'm covered by the CARES act, or is there a better way to make that determination?

A. CMS has extended the repayment of these accelerated/advance payments to begin 120 days after the date of issuance of the payment. The repayment timeline is broken out by provider type. Inpatient acute care hospitals, children's hospitals, certain cancer hospitals and Critical Access Hospitals (CAH) have up to one year from the date the accelerated payment was made to repay the balance. All other Part A providers and Part B suppliers will have 210 days from the date of the accelerated or advance payment was made to repay the balance.

The provider/supplier can continue to submit claims as usual after the issuance of the accelerated or advance payment; however, recoupment will not begin for 120 days. Providers/suppliers will receive full payments for their claims during the 120-day delay period. At the end of the 120-day period, the recoupment process will begin, and every claim submitted by the provider/supplier will be offset from the new claims to repay the accelerated/advanced payment. Thus, instead of receiving payment for newly submitted claims, the provider's/supplier's outstanding accelerated/advance payment balance is reduced by the claim payment amount. This process is automatic.

Q. The Terms and Conditions refer to an attestation form to sign and submit once we have received funds. Where is that form located?

A. It does not appear to have been developed or provided at this time. Continue to monitor both DHHS and CMS COVID-19 websites.

Q. How much is the approximate percentage increase from the basic DRG of the 20% increase of the DRG weight factor?

A. During the emergency period, the legislation provides a 20% add-on to the DRG rate for patients with COVID-19. This add-on applies to patients treated at rural and urban inpatient prospective payment system (IPPS) hospitals. ■



Sources

1. CMS Special Edition Bulletin, April 3, 20202.
2. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6451.pdf>.
3. CMS Claims Manual, Pub 100-04, Chapter 38, Section 10.