Keeping up with COVID-19

Webinar Series

Q&A

June 4, 2020

Securing Revenue for Hospitals and Providers in a COVID-19 Environment

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 portal. 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.

Q. Can you review how cost sharing affects Medicare patients?

A. Medicare beneficiaries who get tested for COVID-19 or receive the COVID-19 serology test are not required to pay the Part B deductible or any coinsurance for this test, because clinical diagnostic laboratory tests are covered under traditional Medicare at no cost sharing. A provision in the Families First Coronavirus Response Act also eliminates beneficiary cost sharing for COVID-19 testing-related services, including the associated physician visit or other outpatient visit (such as hospital observation, E-visit, or emergency department services). A testing-related service is a medical visit furnished during the emergency period that results in ordering or administering the test.
The law also eliminates cost sharing for Medicare Advantage enrollees – both the COVID-19 test and testing-related services – and prohibits the use of prior authorization or other utilization management requirements for these services.

Beneficiaries who are admitted to a hospital for treatment would be subject to the Medicare Part A deductible.

Practitioners have been provided flexibility around waiving cost-sharing for telehealth services during the Public Health Emergency. This is not mandated; but is an individual choice a physician can make. Therefore, Modifier CS, *Cost-sharing for specified COVID-19 testing-related services that result in an order for or administration of a COVID-19 test*, should not be applied as the insurer is not responsible for the cost sharing of these services unless they are provided to determine if the patient should be tested for COVID-19.

Q. How does the current situation impact RCM revenues and profit margins? If it does impact, what is the forecast or prediction of picking up the business and revenue?

A. The American Hospital Association (AHA) undertook four analyses to better understand and quantify these financial challenges. Including:

- ✓ Effect of COVID-19 hospitalizations on hospital costs;
- ✓ Effect of cancelled and forgone services, caused by COVID-19, on hospital revenue;
- ✓ Additional costs associated with purchasing needed personal protective equipment (PPE)
- ✓ Costs of additional support some hospitals are providing to their workers

The report attempts to quantify these effects over the short term, a four-month period from March 1, 2020 to June 30, 2020. Based on these analyses, the AHA estimates a **total four-month financial impact of $202.6 billion** in losses for America's hospitals and health systems, or an average of **$50.7 billion per month**.

https://www.aha.org/guidesreports/2020-05-05-hospitals-and-health-systems-face-unprecedented-financial-pressures-due

Q. Is it possible to avoid denials when coding for sepsis in COVID-19? Can you provide clarification on the coding guidelines regarding COVID-19 coding as a primary diagnosis? If a patient has sepsis or is pregnant, COVID-19 is coded as a secondary diagnosis, per Coding Clinic ICD-10 codes.

A. Without further information on the specific denials your hospital is receiving and from which payers, nThrive cannot give a response tailored to your situation. However, our research indicates that denials concerning the diagnosis of sepsis were on the rise even prior to the COVID-19 public health emergency. nThrive agrees that the pregnancy diagnosis does come first[1], but a sepsis diagnosis depends on the type, when the patient got it and documentation of the condition, so there is not a hard-fast rule as to the coding order.

There are different sets of criteria for determining the diagnosis of sepsis, as well as the level of care that the patient might be assigned. It is important to know which criteria your payers are following so that you can identify the logic behind the denial and take action to improve physician documentation to be as specific as possible. Some of the criteria that insurance companies use include:

Sepsis 1 definition – Systemic Inflammatory Response Syndrome (SIRS) plus known or suspected infection

Sepsis 2 definition – 2 SIRS criteria plus known or suspected infection

Sepsis 3 definition – a life-threatening organ dysfunction due to dysregulated host response to infection (2 points or more in the Sequential Organ Failure Assessment [SOFA] score)

SOFA score – a mortality prediction score based on the degree of dysfunction of six organ systems. This is used to track a patient's status during their stay in the ICU and helps to determine the extent of organ function or rate of failure

An article titled *Avoiding Sepsis Downgrades and Denials* authored by physicians may be found at https://soundphysicians.com/blog/2019/06/03/avoiding-sepsis-downgrades-and-denials/, which offers physicians advice on ensuring the document as specifically as possible in support of a diagnosis of sepsis. The article includes this table outlining sepsis criteria:

	SEPSIS 1	SEPSIS 2	SEPSIS 3
YEAR	1991	2001-2003	2014-2016
SCORING SYSTEM	SIRS	SIRS, expanded criteria set	SOFA: SOFA of 2 or more. 10% in hospital mortality, ICUs qSOFA in ED, Med/Surgical units, out of hospital
DEFINITION	Continuum of SIRS with sepsis if a source is present with hypotension, hypoperfusion, lactic acid positiviy defining severe sepsis, to organ fialure defining sepsis shock.	Expanded definition with additional clinical criteria, PRIO	Life-threatening organ dysfunction caused by a dysregulated response that creates organ failure
STUDY	Consensus statement	Revision of consensus statement	Consensus and data based from ICUs and large EHR data bases
STRENGTHS/ WEAKNESSES	Poor specificity, overly high sensitivity	Improved tool as sepsis screen, but not very specific	Improved spedificity, predicts mortality > 70% of sepsis cases, poor sensitivity 29.7%, poor screening tool for sepsis, studied in ICU population.
ORGANIZING BODY	ACCP and SCCM	SCCM/ESICM/ACCP/ATS/SIS	SCCM and ESICM
DATA-DRIVEN	No	No	Yes
LITERATURE SOURCE	Bone RC, Balk RA, Cerra FB, et al. American College of Chest Physicians/Society of Critical Care Medicine Consensus Confernce: definitions for sepsis and organ failure and guidelines for the use of innovative therapies in sepsis. Critical Care Med 1992;20(6)864-974.	Levy MM, Fink MP, Marshall JC, et al; International Sepsis Definitions Conference. 2001 SCCM/ESICM/ ACCP/ATS/SIS	JAMA. 2016;315(8): 01-810 doi:10.10001/ JAMA 2016.0287

A second article posted to this site addresses sepsis in COVID-19 specifically, *Documenting COVID-19 Patients – Specificity is Key*. This article focuses on building the case for sepsis through very specific documentation regarding risk adjustments and provides CDI tips.

Coding for Risk Adjustment:

- ✓ Diagnose/document using coding-based language as much as possible.
- ✓ Make sure diagnosis(es) is in the chart at least once.
- ✓ Document to the greatest level of specificity.
- ✓ Secondary diagnosis: bucket into one of three groups – Not sick, sick, and very sick.

No SOI	Comorbidity/ Complication (CC, ^ Severity)	Major Comorbidity/ Complication (MCC, ^^^ Severity)
Not Sick	*Sick*	*Very Sick*
Altered Mental Status	Encephalopathy	Metabolic Encephalopathy
DOE, Orthopnea	Chronic Respiratory Failure	ARDS
Hypotension	Shock	Septic Shock

This article contains a link to a free webinar that discusses documentation to support coding the diagnosis of sepsis as well as criteria to support placement in observation, admission to a medical floor and admission to the ICU. The link is found at: https://soundphysicians.com/blog/2020/05/29/documenting-covid-19-patients-specificity-is-key/.

The Health Information Association site has also provided guidance on preventing denials related to sepsis that you may find useful: https://www.hiacode.com/education/reasons-for-denials-and-prevention-for-sepsis/.

We hope this started you in the right direction in resolving your denial issues. If nThrive can be of further assistance in this area, please reach out and allow us to partner with you.

Q. Can you please explain again what the hospital side should be billing if the patient is at home and the physician is in an outpatient hospital location?

A. If the hospital has expanded its walls to include the patient's home as a part of the hospital outpatient provider-based clinic, then both the patient and the physician are considered to be "at the hospital." In this instance, you bill the facility component of the service just as the hospital did pre-COVID-19.

Q. Is there a slide related to billing Telehealth speech therapy visits for a patient in a SNF non Medicare Part A?

A. If the patient is not covered by Medicare, the facility will need to contact and/or adhere to the payer specific guidelines.

Q. For hospitals, is Telehealth being identified as a telehealth encounter level since most services don't require a new procedure code?

A. The inquiry is unclear. The hospital may report as telehealth codes from the 98966-98968 series, and codes for Physical and Occupational Therapy, All levels (CPT codes 97161-97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, and 92507). These therapy codes are reported on the UB claim with Modifier 95, *Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System*. If the hospital meets the guidelines for expansion of walls to include the patient's home, then other options become available for reporting originating site fees for telehealth, as well as other outpatient hospital services provided, using remote telecommunication equipment. We encourage you to visit the nThrive COVID-19 coding update portal for more information: https://www.nthrive.com/covid19.

Q. Will the HRSA program cover an uninsured in-patient visit that was suspected COVID-19 rule out and ended up testing negative for COVID-19?

A. No, not if the inpatient did not have a COVID-19 diagnosis. The COVID-19 diagnosis code **must be the primary diagnosis code submitted for an inpatient stay** and the only exception is for pregnancy (O98.5-), when the COVID-19 code may be listed as secondary[2]. However, HRSA would cover outpatient testing if the result was negative and the patient was not admitted as an inpatient.

Health care providers who have conducted COVID-19 testing for uninsured individuals or provided treatment to uninsured individuals with a COVID-19 diagnosis on or after February 4, 2020, can request claims reimbursement through the program electronically and will be reimbursed generally at Medicare rates, subject to available funding. Reimbursement will be made for qualifying testing for COVID-19 and treatment services with a primary COVID-19 diagnosis as determined by HRSA (subject to adjustment as may be necessary), including the following.

- ✓ Specimen collection, diagnostic and antibody testing.
- ✓ Testing-related visits performed in the office, urgent care, emergency room or via Telehealth.
- ✓ Treatment, including office visits, emergency room, inpatient, outpatient/observation, skilled nursing facility,

long-term acute care (LTAC), acute inpatient rehab, home health, DME (e.g., oxygen, ventilator), emergency ambulance transportation, non-emergent patient transfers via ambulance, and FDA-approved drugs as they become available for COVID-19 treatment and administered as part of an inpatient stay.

- ✓ FDA-approved vaccine, when available.

Testing Codes – Hospitals and Physicians

For diagnostic testing and testing-related services to be eligible for reimbursement, claims submitted for testing-related visits rendered in an office, urgent care or emergency room or via Telehealth setting must include one of the following diagnosis codes.

Z03.818, Encounter for observation for suspected exposure to other biological agents ruled out (possible exposure to COVID-19)

Z20.828, Contact with and (suspected) exposure to other viral communicable (confirmed exposure to COVID-19)

Z11.59, Encounter for screening for other viral diseases (asymptomatic)

For antibody testing and testing-related services to be eligible for reimbursement, claims submitted for testing-related visits rendered in an office, urgent care or emergency room or via telehealth setting must include one of the following procedure codes:

86318, Immunoassay for infectious agent antibody, qualitative or semi-quantitative, single step method (e.g., reagent strip)

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

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

Q. Is HRSA the payer of last resort or do you get Medicaid eligible first?

A. Yes, this funding is typically the last resort. Steps involve enrolling as a provider participant, checking patient eligibility, submitting patient information, submitting claims, and receiving payment via direct deposit. To participate, providers must attest to the following at registration[3].

- ✓ Checked eligibility for any health care coverage.
- ✓ Accepted defined program reimbursement as payment in full.
- ✓ Agreed not to balance bill the patient.
- ✓ Agreed to program terms and conditions and may be subject to post-reimbursement audit review.
- ✓ Ensured all claims submitted are complete and final with a DOS on or after 2/4/20.

Below are some additional facts pertinent to the program.

- ✓ Reimbursement averages per claim range from $13,297 to $40,218.
- ✓ Hospitals in states that chose not to expand Medicaid will receive a larger share of the $100B fund.
- ✓ High wage areas (New York) will experience a larger surge of uninsured COVID-19 patients.
- ✓ Current estimates show around 2 million uninsured individuals could require hospitalization.
- ✓ This funding is claim reimbursements, not loans, so they do not have to be paid back.
- ✓ Payments received should be treated in the same way Medicare, Medicaid, and commercial reimbursements are on the cost report.

Q. What modifier can be used for 87635 to obtain full payment for Outpatient services?

A. Modifier CS indicates that cost-sharing is waived, and the full allowable payment should be received from the payer without any amount shifted to the out-of-pocket responsibility of the patient.

Q. Are hospitals/technical/facility billings now required to use modifier 95 in any capacity related to COVID-19 updates? Mod 95 historically has been professional only. Please address.

A. Modifier 95 would be required for physical and occupational therapy services that are on the current list of eligible telehealth services. In a recent FAQ and confirmed on a June 2, 2020 provider call, CMS confirmed that they have expanded the options for billing hospital-based outpatient therapy services to allow them to also be billed on a UB-04 claim form, the same as the private practice therapist billing on a 1500 claim. See additional information on this issue at the nThrive COVID-19 portal: https://www.nthrive.com/covid19.

Q. Medicaid (Medi-Cal) California does not accept U0002 but they prefer to bill this test with CPT 87635.

A. Report codes as directed by Non-Medicare payers.

Q. What is the proper modifier to use for hospital ER/ Outpatient COVID-19 test and related services….CS or CR?

A. Modifier CS is used to indicate the waiver of patient cost-sharing. This modifier is necessary to receive accurate payment from the insurer for testing and the related E/M that led to the testing. Modifier CR, *Catastrophe/disaster related*, is informational and does not impact payment. Both may be applied to the claim.

Q. Are telehealth services for psychiatry, diabetes, and geriatrics claims in a hospital facility supposed to billed with modifier 95?

A. For services provided by hospital-employed staff in a hospital outpatient provider-based clinic the services you listed may be billed on UB-04 claim under one of two options depending upon the service. PT and OT services found on the CMS list of eligible telehealth services, rendered by telehealth mechanisms would be billed with Modifier 95. Other non-therapy hospital outpatient services may be billed on a UB if the hospital has met the criteria to expand its wall to include the patient's home. These services are reported using the same CPT codes as were used pre-COVID-19 with either Modifier PO or PN. See additional information on this issue at the nThrive COVID-19 portal: https://www.nthrive.com/covid19.

Q. Medicare Fee for Service and Medicare Advantage are applying the deductible on COVID-19 claims when the COVID-19 diagnosis appear as secondary diagnosis. Please explain the NO COST reimbursement rule.

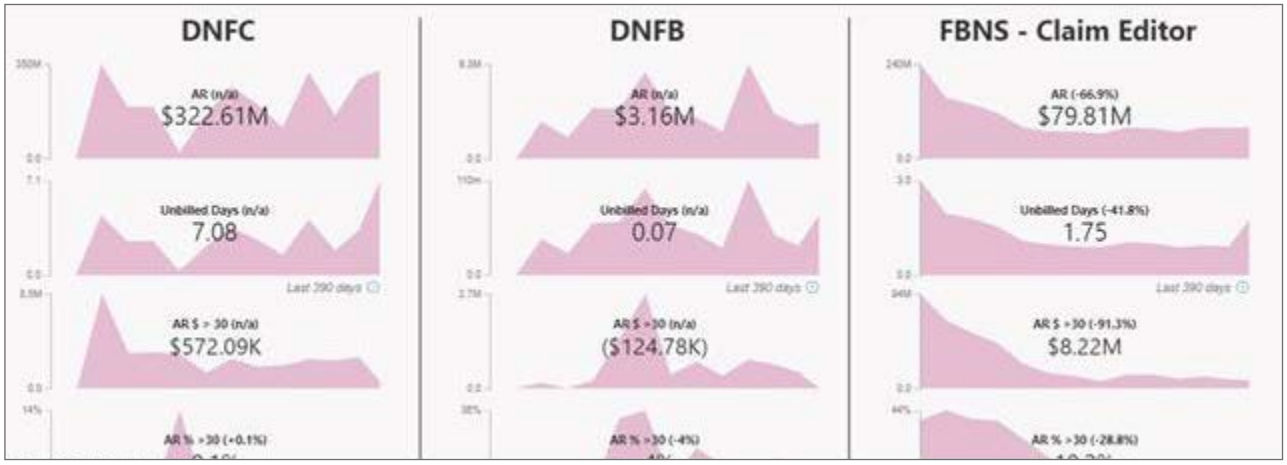
A. CMS has confirmed on various provider calls that the position of the COVID-19 related diagnosis code on the claim should not impact reimbursement. It is not the diagnosis that drives the waiver of cost-sharing. The provider must apply Modifier CS to the claim that includes testing to ensure that both the insurer and the patient's responsibility are paid by the insurer.

Q. Does nThrive exhibit all payor specific COVID-19 and telehealth edits? Do you have system indicators for identification of COVID-19 other than testing codes?

A. nThrive Claims Management has addressed payer edits for many payers in response to the changes needed to address COVID-19 billing, as well as accommodating the needed changes to allow for expanded telehealth billing. The nThrive Claims Management team publishes bi-weekly edit changes and can be referenced for the specific edits addressed. Claims management edits use several elements to define COVID-19 claims which may include testing codes, diagnosis codes, or in combination. Client specific questions can be submitted via our Client Portal.

Q. Can you share your daily dashboard example and your DNFB comparison strategy and document without PHI?

A. Yes, following is a generic template. Please note that nThrive Revenue Cycle Analyzer has a dashboard that tracks and trends DNFC, DNFB, and FBNS. As a result, we can also drill down into the numeric KPI's as well. However, because RCA is customizable, we can also create the exact dashboard and KPI's related to DNFB you are looking for. Below is an illustration of a DNFB dashboard currently in RCA.



Sources

1. ICD-10-CM Official Coding and Reporting Guidelines April 1, 2020 through September 30, 2020, Chapter 1 and Chapter 15
2. https://www.hrsa.gov/coviduninsuredclaim
3. https://www.hrsa.gov/coviduninsuredclaim