

GET PAID FOR TELEHEALTH; NEW RULES FOR DOCUMENTATION AND TECHNOLOGY

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Disclaimer

- This material is designed to offer basic information for coding and billing. The information presented here is based on the experience, training, and interpretation of the author. Although the information has been carefully researched and checked for accuracy and completeness, the instructor does not accept any responsibility or liability with regard to errors, omissions, misuse, or misinterpretation. This handout is intended as an educational a guide and should not be considered a legal/consulting opinion.
- This information is current as of the date the lecture was written –
- April 6, 2020

Corona Virus – COVID-19 vs Healthcare

- HB6074-Corona Preparedness and Response Supplemental Appropriations Act of 2020 (March 6, 2020)
- Waiver section 1135 of the Social Security Act (the Act)
- Daily changes have been seen to the multiple insurance payers
- CMS continues to release clarifying Q&A in several areas

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Telemedicine vs Telehealth

- World Health Organization (WHO) uses terms interchangeably
 - “Some distinguish telemedicine from telehealth with the former restricted to service delivery by physicians only, and the latter signifying services provided by health professionals in general, including nurses, pharmacists, and others.”

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AAFP Website

- **Telemedicine** is the practice of medicine using technology to deliver care at a distance. It occurs using a telecommunications infrastructure between a patient (at an originating or spoke site) and a physician or other practitioner licensed to practice medicine (at a distant or hub site).
- **Telehealth** refers to a broad collection of electronic and telecommunications technologies that support health care delivery and services from distant locations. Telehealth technologies support virtual medical, health, and education services.

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Coronavirus Preparedness and Response Supplemental Appropriations Act

- Signed into law by the President on March 6, 2020
- Includes a provision to waive certain Medicare telehealth payment requirements during the Public Health Emergency (PHE) declared by the Secretary of Health and Human Services January 31, 2020

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CMS-1744-IFC

- Medicare & Medicaid Programs: Policy and Regulatory Revisions in Response to COVID-19 Public Health
- Interim Final Rule with Comment Period (aka “Final Rule”)
- Effective March 1, 2020

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Telemedicine

- Originating Site
 - The location where a Medicare beneficiary gets physician or practitioner medical services through a telecommunications system.
 - A county outside a Metropolitan Statistical Area (MSA)
 - A rural Health Professional Shortage Area (HPSA) in a rural census tract
- Originating Sites Per CMS
 - Physicians or practitioner offices.
 - Hospitals.
 - Critical access hospitals (CAHs)
 - Rural health clinics.
 - Federally qualified health centers (FQHCs)
 - Hospital-based or CAH-based renal dialysis centers (including satellites)
 - Skilled nursing facilities.
 - Community mental health centers

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Telehealth Originating Site

- HCPCS Code Q3014 describes the Medicare telehealth originating sites facility fee
- Bill your MAC for the separately billable Part B originating site facility fee

Telemedicine – Originating Site

- May be any location patient is experiencing the encounter from
 - Home
 - Nursing Home
 - Daughter's house
- Beginning March 6, 2020

CHANGE
eff:3-6-20

Telemedicine – Distance Site Practitioners

- Distant site practitioners who can furnish and get payment for covered telehealth services (subject to State law) are:
 - Physicians
 - Nurse practitioners (NPs)
 - Physician assistants (PAs)
 - Nurse-midwives
 - Clinical nurse specialists (CNSs)
 - Certified registered nurse anesthetists
 - Clinical psychologists (CPs) and clinical social workers (CSWs) CPs and CSWs cannot bill Medicare for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services. They cannot bill or get paid for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838.

Telemedicine Payment Differential

99213 - Telemedicine (POS 02)

- 99213 – 1.45 RVU
- Q3014 approx. 0.72 RVU

- Initial instructions bill
Telemedicine service

- 99201-99215

- Place of service

- 02 Telehealth

- No modifier

99213 - Office (POS 11)

- 99213 - 2.11 RVU

- NEW instructions bill

- Telemedicine service

- 99201-99215

- Place of Service usually performed at

- i.e. office POS 11

- Modifier 95 – Synchronous
Telemedicine service

Telemedicine - Live Video (synchronous)

- *Interactive telecommunications system* means multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner

Telemedicine – Telecommunication Equipment

- Providers may use any **non-public facing** remote communication product that is available to provide telehealth to patients during the COVID-19 nationwide public health emergency
- Office for Civil Rights (OCR) is exercising its enforcement discretion to not impose penalties for noncompliance with the HIPAA Rules in connection with the good faith provision of telehealth
- This exercise of discretion applies to telehealth provided for any reason, regardless of whether the telehealth service is related to the diagnosis and treatment of health conditions related to COVID-19.

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eff: 3-6-20

Telemedicine – Telecommunication Equipment

- Mobile computing devices with audio and video capabilities may be used
 - They qualify as acceptable technology
 - During the COVID-19 nationwide public health emergency
 - FaceTime
 - Skype
 - Added in HHS.gov - Notification of Enforcement Discretion for Telehealth remote.
 - Allow
 - Updox, VSee, Zoom for Healthcare, Doxy.me and Google G Suite Hangouts Meet. Also allowed as acceptable non secure: Apple Face Time, Facebook Messenger video chat, Google Hangouts video or Skype.
 - Cannot use:
 - Facebook Live, Twitch, Tik Tok

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eff: 3-6-20

Telemhealth

- New patient's allowed
- Patient's Consent
 - Final Rule allows
 - Auxiliary staff under general supervision
 - Some codes annually
 - Some codes each occurrence

Telemedicine – Patient’s Financial Liability

- Telehealth does not change the out of pocket costs for beneficiaries with Original Medicare
 - Beneficiaries are generally liable for their deductible and coinsurance
- Office of Inspector General (OIG) is providing flexibility
 - Providers may reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs

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Telemedicine/Telehealth - Deductible

- Until further notice, HHS will not take enforcement action against any health insurance issuer that amends its catastrophic plans to provide pre-deductible coverage for services associated with the diagnosis and/or treatment of COVID-19

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eff:3-6-20

TELEMEDICINE- Modifier G0 - Acute Stroke

- Restrictions removed on geographic location and on originating sites
- Acute Stroke Telehealth
 - May be furnished in any hospital, critical access hospital, mobile stroke unit or any other site determined appropriate by the Secretary
- Use modifier G0 (“G” “zero”) to identify Telehealth services furnished for
 - Diagnosis, evaluation or treatment of symptoms of an acute stroke
- After January 1, 2019



Telemedicine Documentation 1995 E&M Guidelines

You may use time for your E&M services

99213- 15 minutes

99214 – 25 minutes

Traditional E&M documentation (use History and MDM)

99213 – HPI – 1

ROS – 1 (pertinent to problem)

PFSH (none required)

MDM – Low

99214 – HPI – 4

ROS – 2+

PFSH – 2

MDM - Moderate

Beneficiary HIC #: _____

3. Medical Decision Making

Number of Diagnoses or Treatment Options
Identify each problem or treatment option mentioned in the record. Enter the number in each of the categories in Column B in the table below. (There are maximum number in two categories.) Do not categorize the problem(s) if the encounter is dominated by counseling/coordinates of care, and duration of time is not specified. In that case, enter 3 in the total box.

Number of Diagnoses or Treatment Options			
A	B	X	C = D
Problem(s) Status	Number	Points	Result
Self-limited or minor (stable, improved or worsening)	Max = 2	1	
Est. problem (to examiner); stable, improved		1	
Est. problem (to examiner); worsening		2	
New problem (to examiner); no additional workup planned	Max = 1	3	
New prob. (to examiner); add. workup planned		4	
TOTAL			

Amount and/or Complexity of Data Reviewed
For each category of reviewed data identified, circle the number in the points column. Total the points.

Amount and/or Complexity of Data Reviewed	
Reviewed Data	Points
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	2
TOTAL	

After completing this table, which classifies complexity, circle the type of decision making within the appropriate grid.

Final Result for Complexity	99212	99213	99214	99215
A Number diagnoses or treatment options	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
B Highest Risk	Minimal	Low	Moderate	High
C Amount and complexity of data	≤ 1 Minimal or low	2 Limited	3 Multiple	≥ 4 Extensive
Type of decision making	STRAIGHT-FORWARD	LOW-COMPLEX	MODERATE-COMPLEX	HIGH-COMPLEX

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Risk of Complications and/or Morbidity or Mortality
most appropriate factor(s) in each category. The overall measure of risk is the highest level circled. Enter the level of risk identified in Final Result for Complexity (table below).

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	<ul style="list-style-type: none"> One self-limited or minor problem, e.g., cold, insect bite, tinea corporis 	<ul style="list-style-type: none"> Laboratory tests requiring venipuncture Chest x-rays EKG/EEG Urinalysis Ultrasound, e.g., echo KOH prep 	<ul style="list-style-type: none"> Rest Gargles Elastic bandages Superficial dressings
Low	<ul style="list-style-type: none"> Two or more self-limited or minor problems One stable chronic illness, e.g., well controlled hypertension or non-insulin dependent diabetes, cataract, BPH Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain 	<ul style="list-style-type: none"> Physiologic tests not under stress, e.g., pulmonary function tests Non-cardiovascular imaging studies with contrast, e.g., barium enema Superficial needle biopsies Clinical laboratory tests requiring arterial puncture Skin biopsies 	<ul style="list-style-type: none"> Over-the-counter drugs Minor surgery with no identified risk factors Physical therapy Occupational therapy IV fluids without additives
Moderate	<ul style="list-style-type: none"> One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis, e.g., lump in breast Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis Acute complicated injury, e.g., head injury with brief loss of consciousness 	<ul style="list-style-type: none"> Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test Diagnostic endoscopies with no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis 	<ul style="list-style-type: none"> Minor surgery with identified risk factors Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors Prescription drug management Therapeutic nuclear medicine IV fluids with additives Closed treatment of fracture or dislocation without manipulation
High	<ul style="list-style-type: none"> One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss 	<ul style="list-style-type: none"> Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic endoscopies with identified risk factors Discography 	<ul style="list-style-type: none"> Elective major surgery (open, percutaneous or endoscopic) with identified risk factors Emergency major surgery (open, percutaneous or endoscopic) Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis

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Telemedicine – Office **ONLY** Modified 2021 Rules

- Office/outpatient E/M level selection for services when furnished via telehealth can be based on MDM or time
 - Use current definition of MDM
- This removed any requirements regarding documentation of history and/or physical exam in the medical record*
- This is a policy revision on an interim basis, only
 - Policy similar to policy beginning in 2021

Telemedicine – Office **ONLY**

- Time defined as all of the time associated with the E/M on the day of the encounter
 - Time personally spent by the reporting provider
 - NO ONE ELSE'S TIME!!!
 - Including face-to-face and non face-to-face time



Telemedicine and Time

- If the code is based on time
 - Must meet or exceed minimum threshold of time for the code
 - Document total time of the visit
 - Showing you are meeting requirements of code

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Telemedicine Services Added During PHE

- Emergency Department Visits
- Observation code series (admit and discharge)
- Initial Hospital Care Visits
- Nursing Facility Visits
- Domiciliary, Rest Home, or Custodial Care Services
- Home Visits
- Inpatient Neonatal and Pediatric Critical Care Visits
- End Stage Renal Disease Visits
- Psychology and Neuropsychology Testing

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Listing of Telehealth Services Allowed in 2020

- <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Downloads/covered-telehealth-services.zip>
- 80 additional codes have been added

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Telemedicine - Hospital

- Subsequent hospital care services are limited to one telehealth visit every 3 days
 - Not intended to apply to consulting physicians or practitioners
- Subsequent nursing facility care services are limited to one telehealth visit every 30 days
 - Federally mandated periodic visit MAY NOT reported utilizing Telehealth
 - Not intended to apply to consulting physicians or practitioners

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Telemedicine – Electronic Prescriptions

- As of March 16, 2020, and continuing for as long as the Secretary's designation of a public health emergency remains in effect
 - DEA-registered practitioners in all areas of the United States may issue prescriptions for all schedule II-V controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided **ALL** of the following conditions are met:
 - The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice
 - The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system
 - The practitioner is acting in accordance with applicable Federal and State laws

Telemedicine – Electronic Prescriptions

- If prescribing practitioner has previously conducted an in-person medical evaluation of the patient
 - May issue a prescription for a controlled substance after having communicated with the patient
 - Via telemedicine
 - Any other means
- NOTE
 - This is regardless of whether a public health emergency has been declared by the Secretary of Health and Human Services
 - So long as the prescription is issued for a legitimate medical purpose
and
 - The practitioner is acting in the usual course of his/her professional practice

Telemedicine - Licensure

- A practitioner providing services via telehealth must be licensed in the state in which the patient is located.

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Telemedicine - Licensure

- 1135 waivers allow CMS to waive, on an individual basis, the Medicare requirement that a physician or non-physician practitioner must be licensed in the State in which s/he is practicing
- Does not have the effect of waiving State or local licensure requirements or any requirement specified by the State or a local government as a condition for waiving its licensure requirement

Telemedicine - Licensure

- This is not available unless all of the following four conditions are met:
 - 1) the physician or non-physician practitioner must be enrolled as such in the Medicare program
 - 2) the physician or non-physician practitioner must possess a valid license to practice in the State which relates to his or her Medicare enrollment
 - 3) the physician or non-physician practitioner is furnishing services – whether in person or via telehealth – in a State in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity
 - 4) the physician or non-physician practitioner is not affirmatively excluded from practice in the State or any other State that is part of the 1135 emergency area

Telehealth – Location of Provider

- Final Rule --Allows practitioners to render telehealth services from their home
 - Without reporting their home address on their Medicare enrollment
 - May continue to bill from currently enrolled location.

Provider Enrollment – CMS (Released 3-23-20)

Fasttrack

Physicians & Non-Physician Practitioners

- Establish toll free hotlines to enroll and receive temporary Medicare billing privileges
- Waive the following screening requirements:
 - Criminal background checks associated with fingerprint-based criminal background checks (FCBC) (to the extent applicable)
 - Site visits
 - Postpone all revalidation actions

Provider Enrollment – CMS (Released 3-23-20)

Fasttrack

- Calling the enrollment hotline to initiate temporary billing privileges, you will be asked to provide limited information
- Your Medicare Administrative Contractor (MAC) will attempt to screen and enroll the physician or non-physician practitioner over the phone
 - Temporary billing privileges
- When emergency is lifted, will need to submit an enrollment application

Telemedicine and HIPAA

- HIPAA Privacy Rule permits entities to disclose PHI without a patient's authorization
- Covered entities may disclose PHI about the patient as necessary to treat the patient or to treat a different patient
- Covered entities may disclose requested PHI to a public health authority, a foreign government agency (at the direction of a public health authority) that is collaborating with the public health authority, and persons at risk of contracting or spreading a disease or condition if authorized by law.
- Covered entities may share PHI with a patient's family, friends, relatives, or other persons identified that were involved in the patient's care
- Health care providers may share PHI with anyone in order to prevent or lessen a serious and imminent threat to the public health and safety

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Telemedicine and HIPAA

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Telemedicine – Diagnoses Allowed

- Telehealth provision allows care without regard to the diagnosis of the patient
- Prevent vulnerable beneficiaries from unnecessarily entering health care facility when needs can be met remotely
- Example cited, patient needing a visit with physician for refill of medication
- Services must still be reasonable and necessary

CHANGE
eff: 3-6-20

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ICD-10 Coding

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New Code effective April 1, 2020

- Chapter 22
- Codes for special purposes (U00-U85)
- Provisional assignment of new diseases of uncertain etiology or emergency use (U00-U49)
- **Note: Codes U00-U49 are to be used by WHO for the provisional assignment of new diseases of uncertain etiology.**
- U07 Emergency Use of U07



New Code effective April 1, 2020

- **U07.1 - COVID-19**
- **Use additional code to identify pneumonia or other manifestations.**
- **Excludes1: Coronavirus infection, unspecified (B34.2)**
 Coronavirus as the cause of diseases classified elsewhere (B97.2-)
 Pneumonia due to SARS associated coronavirus (J12.81)



Code Only Confirmed Cases Eff 4/1/2020

- Code only a confirmed diagnosis of the 2019 novel coronavirus disease (COVID-19) as documented by the provider
 - Documentation of a positive COVID-19 test result
 - Presumptive positive COVID-19 test result
 - This is an exception to the hospital inpatient guideline Section II
- For a confirmed diagnosis, assign code U07.1, COVID-19
 - In this context, “confirmation” does not require documentation of the type of test performed
 - The provider’s documentation that the individual has COVID-19 is sufficient.



Presumptive Positive Eff 4/1/2020

- These should be coded as confirmed
- A presumptive positive test result means an individual has tested positive for the virus at a local or state level
 - Not yet been confirmed by the Centers for Disease Control and Prevention (CDC)
- CDC confirmation of local and state tests for COVID-19 is no longer required



ICD-10-CM Coding Pneumonia

**February 20, 2020 to
March 31, 2020**

- Patients with pneumonia, case confirmed as due to the 2019 novel coronavirus (COVID-19), assign
 - J12.89 - Other viral pneumonia
 - AND
 - B97.29 - Other coronavirus as the cause of diseases classified elsewhere

**April 1, 2020 to
September 30, 2020**

- Patients with pneumonia confirmed as due to the 2019 novel coronavirus (COVID-19) assign
 - U07.1 – COVID-19
 - AND
 - J12.89 - Other viral pneumonia.



ICD-10-CM Coding Acute Bronchitis

**February 20, 2020 to
March 31, 2020**

- Patients with acute bronchitis confirmed as due to COVID-19, assign
 - J20.8 - Acute bronchitis due to other specified organisms

AND

- B97.29 - Other coronavirus as the cause of diseases classified elsewhere

**April 1, 2020 to
September 30, 2020**

- Patients with acute bronchitis confirmed as due to COVID-19, assign
 - U07.1 – COVID-19

AND

- J20.8 - Acute bronchitis due to other specified organisms.



ICD-10-CM Coding Bronchitis not otherwise specified (NOS)

**February 20, 2020 to
March 31, 2020**

Patients with bronchitis (NOS) due to the COVID-19, assign

- J40 - Bronchitis, not specified as acute or chronic
- AND*
- B97.29 -Other coronavirus as the cause of diseases classified elsewhere

**April 1, 2020 to
September 30, 2020**

• Patients with Bronchitis not otherwise specified (NOS) due to COVID-19 assign

- U07.1 – COVID-19
- AND*
- J40, Bronchitis, not specified as acute or chronic.



ICD-10-CM Coding Lower Respiratory Infection

February 20, 2020 to

March 31, 2020

Respiratory Infection

- Patients with COVID-19 documented as being associated with a lower respiratory infection, not otherwise specified (NOS), or an acute respiratory infection, NOS, assign
 - J22 - Unspecified acute lower respiratory infection

AND

- B97.29 - Other coronavirus as the cause of diseases classified elsewhere

April 1, 2020 to

September 30, 2020

- Patients with COVID-19 documented as being associated with a lower respiratory infection, not otherwise specified (NOS), or an acute respiratory infection, NOS assign
 - U07.1 – COVID-19

AND

- J22, Unspecified acute lower respiratory infection



ICD-10-CM Coding Respiratory Infection

February 20, 2020 to

March 31, 2020

- Patients with COVID-19 documented as being associated with a respiratory infection, NOS, assign
 - J98.8 - Other specified respiratory disorders

AND

- B97.29 - Other coronavirus as the cause of diseases classified elsewhere

April 1, 2020 to

September 30, 2020

- Patients with COVID-19 documented as being associated with a respiratory infection, NOS assign
 - U07.1 – COVID-19

AND

- J98.8, Other specified respiratory disorders



ICD-10-CM Coding Acute respiratory distress syndrome (ARDS)

February 20, 2020 to

March 31, 2020

- ARDS may develop in with the COVID-19
- Patients with ARDS due to COVID-19, assign
 - J80 - Acute respiratory distress syndrome

AND

- B97.29 - Other coronavirus as the cause of diseases classified elsewhere

April 1, 2020 to

September 30, 2020

- Patients with acute respiratory distress syndrome (ARDS) due to COVID-19, assign
 - U07.1 – COVID-19

AND

- J80 - Acute respiratory distress syndrome



ICD-10-CM Coding Exposure to COVID-19

February 20, 2020 to

March 31, 2020

- Patients where there is a concern about a possible exposure to COVID-19, but this is ruled out after evaluation, assign
 - Z03.818 - Encounter for observation for suspected exposure to other biological agents ruled out

April 1, 2020 to S

eptember 30, 2020

- Patients where there is a concern about a possible exposure to COVID-19, but this is ruled out after evaluation, assign
 - Z03.818 - Encounter for observation for suspected exposure to other biological agents ruled out.



ICD-10-CM Coding Exposure to COVID-19

February 20, 2020 to

March 31, 2020

- Patients where there is an actual exposure to someone who is confirmed to have COVID-19, assign
 - Z20.828 - Contact with and (suspected) exposure to other viral communicable diseases

April 1, 2020 to

September 30, 2020

- Patients where there is an actual exposure to someone who is confirmed or suspected (not ruled out) to have COVID-19, and the exposed individual either tests negative or the test results are unknown, assign
 - Z20.828, Contact with and (suspected) exposure to other viral communicable diseases.
- If the exposed individual tests positive for the COVID-19 virus, see guideline (starting slide 7)



ICD-10-CM Coding Screening

February 20, 2020

to March 31, 2020

April 1, 2020

to September 30, 2020

- Patients who are asymptomatic who are being screened for COVID-19 and have no known exposure to the virus, and the test results are either unknown or negative, assign
 - Z11.59 - Encounter for screening for other viral diseases.



ICD-10-CM Coding Asymptomatic Patients

**February 20, 2020
to March 31, 2020**

**April 1, 2020
to September 30, 2020**

- Patients who are being screened due to a possible or actual exposure to COVID-19
 - See guideline (Exposure)
- Patients who are asymptomatic individual is screened for COVID-19 and tests positive
 - See guideline (Asymptomatic patient who tests positive)



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ICD-10-CM Coding Signs and Symptoms

**February 20, 2020
to March 31, 2020**

**April 1, 2020
to September 30, 2020**

- Patients presenting with any signs/symptoms (such as fever, etc.) and where a definitive diagnosis has not been established, assign codes for the Signs & Symptoms (S&S)
 - R05 - Cough
 - R06.02 - Shortness of breath
 - R50.9 - Fever, unspecified
- Patients presenting with any signs/symptoms associated with COVID-19 (such as fever, etc.) but a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms such as:
 - R05 - Cough
 - R06.02 Shortness of breath
 - R50.9 Fever, unspecified



ICD-10-CM Coding Asymptomatic Patients who Test Positive

**February 20, 2020
to March 31, 2020**

**April 1, 2020
To September 30, 2020**

- Patients who are asymptomatic who test positive for COVID-19, assign
 - U07.1 - COVID-19
- Although the individual is asymptomatic, the individual has tested positive and is considered to have the COVID-19 infection.



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ICD-10 Coding Pregnancy, Childbirth and the Puerperium

- During pregnancy, childbirth or the puerperium, a patient admitted (or presenting for a health care encounter) because of COVID-19 should be assigned
 - O98.5- - Other viral diseases complicating pregnancy, childbirth and the puerperium
 - U07.1 - COVID-19, and the appropriate codes for associated manifestation(s)
- Codes from Chapter 15 always take sequencing priority



ICD-10-CM Coding – Effective February 20, 2020

DOCUMENTATION

- If the provider documents “suspected”, “possible” or “probable” COVID-19
 - DO NOT assign code B97.29 - Other coronavirus as the cause of diseases classified elsewhere
 - Assign a code(s) explaining the reason for encounter
 - i.e. fever
 - i.e. - Z20.828 - Contact with and (suspected) exposure to other viral communicable diseases



Care Codes

Care Codes

- Electronic
 - Email
 - Patient portal
- Telephone
 - Audio only
- Telephone and Visual
 - Smart phone
 - Skype
 - Face time
 - Outward Facing technology

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Electronic

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Online Digital Evaluation & Management Services (Physician or other QHCP)

- **Online digital** evaluation and management service, for an **established patient**, for up to 7 days, cumulative time during the 7 days:
 - 99421 - 5-10 minutes
 - 99422 - 11-20 minutes
 - 99423 - 21 or more minutes

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Online Digital Evaluation & Management Services (Physician or other QHCP)

- Patient initiated services through HIPAA compliant secure platform
 - Secure email
 - Electronic health record portal
- Provided by Physicians or other QHCP
- ~~Only for established patients~~ **Final Rule – New patients allowed**
- Reported for cumulative time reported once during a seven day period devoted to service during the period
- Verbal consent for use of communication-based technology (CBTS) services
 - Documented annually

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Online Digital Evaluation & Management Services (Physician or other QHCP)

- Require Physician or other QHCP's evaluation, assessment and management of patient
- NOT for non-evaluative electronic communication of test results, scheduling of appointment or other communication that does not include E&M
- Require permanent documentation of encounter
- Clinical Staff time NOT included in total time

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Online Digital Evaluation & Management Services (Physician or other QHCP)

- Begins with physician or other QHCP's initial, personal review of patient generated inquiry
- Cumulative service time includes review of
 - Initial patient generated inquiry
 - Patient records or data pertinent to assessment of patient's problem
 - Development of management plans (including prescription generation)
 - Physician or other QHCP interaction with clinical staff focused on the patient's problem
 - Subsequent communication with the patient though online, telephone, email or other digitally supported E&M service

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Online Digital Evaluation & Management Services

- **Qualified non-physician health care** professional online digital assessment and management service for an ~~established patient~~, for up to 7 days, cumulative time during the 7 days
 - G2061 - 5 - 10 minutes
 - G2062 - 11 – 20 minutes
 - G2063 - 21 or more minutes
- For clinicians who do NOT have E&M codes within their scope of practice
 - PT, OT, SLP, Clinical Psychologist

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Online Digital Evaluation & Management Services

- **Qualified non-physician health care professional** online digital evaluation and management service for an ~~established patient~~, for up to 7 days, cumulative time during the 7 days
 - 98970 - 5 - 10 minutes
 - 98971 - 11 – 20 minutes
 - 98972 - 21 or more minutes
- For clinicians who do NOT have E&M codes within their scope of practice
- Not recognized by Medicare (see G2061-G2063)

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Technology Based Service-Store & Forward

- 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
- Follow up with patient
 - Phone call
 - Audio/video communication
 - Secure text messaging
 - Email
 - Patient portal communication

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G2010 – Store and Forward

- ~~Only for established patients~~ **Final Rule – New patients allowed**
- Practitioner's evaluation of a patient generated still or video image transmitted by the patient
 - Subsequent communication of the practitioner's response to the patient
 - Unlike G2012 which is realtime
- Verbal consent needs to be noted in the record for EACH instance of use of code
- No frequency limitations at this time
- Co-Pays apply
- Must be performed by a billing provider
 - Clinical staff contact not billable
- Not considered Telehealth (none of their restrictions)

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Telephone

Not originating from a related E&M service provided within the prior 7 days

Nor

Leading to an E/M service or procedure within the next 24 hours or soonest available appointment

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Initiated by Patient

- **CMS NEWS RELEASE**
- "We expect that these virtual services will be initiated by the patient; however, practitioners may need to educate beneficiaries on the availability of the service prior to patient initiation".
- Patients would contact office regarding need for care (with a problem).
- I see this education of beneficiaries to mean the patient would need to be told of the option of the various types of Telehealth services

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Non-Face-To-Face Services – Telephone Services (Physician or Other QHCP)

- Telephone evaluation and management service provided by a **physician** or other qualified health care professional who may report evaluation and management services provided to an ~~established patient~~, parent, or guardian 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;
 - 99441 - 5-10 minutes of medical discussion
 - 99442 - 11-20 minutes of medical discussion
 - 99443 - 21-30 minutes of medical discussion

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EFF 3-1-2020

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Non-Face-To-Face Services – Telephone Services (Physician or Other QHCP)

- Non face-to-face evaluation and management service
 - Via telephone
- Provided by Physician or other QHCP
- Care/contact initiated by patient
 - Patient may need to be educated on availability of services
- Patient must be established with physician/practice

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Non-Face-To-Face Services – Telephone Services (Physician or Other QHCP)

- If service ends with decision to see the patient within 24 hours or next available appointment
 - Do NOT report code
- If service refers to E&M service performed within the prior 7 days or within post operative period
 - Service is considered part of the service or procedure

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Non-Face-To-Face Services – Telephone Services (Non physician)

- Telephone evaluation and management service provided by a **qualified non-physician** health care professional to an ~~established patient~~, parent, or guardian 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;
 - 98966 - 5-10 minutes of medical discussion
 - 98967 - 11-20 minutes of medical discussion
 - 98968 - 21-30 minutes of medical discussion

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EFF 3-1-2020

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Technology Based Service-Virtual Check In

- 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

G2012 – Virtual Check In

- Only **established patients**
- Only real-time audio only telephone interactions in addition to synchronous, two way audio interactions enhanced with video or other kinds of data transmission
- Verbal consent needs to be noted in the record for EACH instance of use of code
- No frequency limitations at this time
- Co-Pays apply
- Must be performed by a billing provider
 - Clinical staff contact not billable
- Not considered Telehealth (none of their restrictions)

G2012 – Virtual Check In

- Historically, any routine non face-to-face communication that takes place before or after an in-person visit to be bundled into the payment for visit
- Amount of face-to-face work for certain kinds of patients rise higher than for others
 - Creates disparities in payment
- Advances in communication technology have changed patients' and practitioners' expectations regarding the quantity and quality of information that can be conveyed via communication technology
- Brief check in services via communication technology to evaluate whether or not an office visit or other service is warranted
 - When furnished prior to an office visit
 - Considered bundled in
 - When check in service does not lead to an office visit
 - No office visit to bundle into

Supervision

- Use of real-time, audio and video telecommunications technology allows for a billing practitioner to observe the patient interacting with or responding to the in-person clinical staff through virtual means, and thus, their availability to furnish assistance and direction could be met without requiring the physician's physical presence in that location
 - Mostly NP/PA
- The presence of the physician includes virtual presence through audio/video real-time communications technology when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider
 - Mostly Auxiliary staff

Telehealth – Incident To

- “We believe that telecommunications technology could be used in a manner that would facilitate the physician’s immediate availability to furnish assistance and direction without necessarily requiring the physician’s physical presence in the location where the service is being furnished, such as the office suite or the patient’s home.”
- “We believe that use of real-time, audio and video telecommunications technology allows for a billing practitioner to observe the patient interacting with or responding to the in-person clinical staff through virtual means, and thus, their availability to furnish assistance and direction could be met without requiring the physician’s physical presence in that location .”

• Final Rule page 56

Telehealth – Incident To

- “Consequently, we are revising the definition of direct supervision to allow, for the duration of the PHE for the COVID-19 pandemic, direct supervision to be provided using real-time interactive audio and video technology .”

• Final Rule page 56

Other Insurances????

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Telemedicine - Medicaid

- States have broad flexibility to cover telehealth through Medicaid. No federal approval is needed for state Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for face-to-face services.
- A state plan amendment would be necessary to accommodate any revisions to payment methodologies to account for telehealth costs.

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TELEMEDICINE – State of Michigan

- Expanded access to telemedicine by immediately allowing Medicaid beneficiaries to receive services in their home while the state combats COVID-19.



For more information, visit Michigan.gov/Coronavirus.

ISSUE TRACK NUMBER – DOCUMENT NUMBER 03/17/2020

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For more information, visit Michigan.gov/Coronavirus.

ISSUE TRACK NUMBER – DOCUMENT NUMBER 03/17/2020

General Telemedicine Policy Expansion

Current telemedicine policy requires both audio and visual service delivery, and when all possibilities to provide services using both audio and visual have been deemed not possible, due to the COVID-19 pandemic the Michigan Department of Health and Human Services (MDHHS) is expanding telemedicine policy.

During the period with dates of service referenced above, all codes on the telemedicine database (which encompass primary care, behavioral health, etc.) will be allowed for the service delivery method **telephonic (audio) only**. (See telemedicine database attached.)

All other requirements of telemedicine policy, including scope of practice requirements, as represented in Bulletin MSA 20-09 and the Medicaid Provider Manual must be followed unless otherwise indicated by the Center for Medicare & Medicaid Services (CMS).

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Telemedicine – FQHC and RHC

- Both FQHC and RHC may serve as distant site telehealth providers for Medicare
 - During national emergency period
- Both FQHC and RHC may provide visiting nursing services at a Medicare patient's home with fewer requirements
 - During national emergency period

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Telemedicine – Medicare Advantage

- Organizations/Plans informed by CMS
 - They may “if they wish” to expand coverage of telehealth services beyond what has already been approved by CMS
 - CMS will exercise its “enforcement discretion”
 - Until determined that it is no longer necessary

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Telemedicine – Medicare Advantage

- Organizations/Plans have flexibility to expand their coverage of telehealth
- Each plan decides individually what they will do
- MA are required to provide what is covered by Fee-for-service (normal)
- Plans do **NOT** have to provide these more expansive telehealth services

Aetna – An Example of variables

- Effective January 1, 2020, Aetna will cover telemedicine services for members enrolled in all Aetna commercial plans
- Reimbursement will be made for two-way, real-time audiovisual interactive communication between the patient and the health care practitioner
- Beginning March 6, 2020 and ending June 4, 2020
 - Zero copays
- Instructions to use one of the following modifiers
 - GT: Telehealth service rendered via interactive audio and video telecommunications system
 - 95: Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system
- Cost sharing is waived for delivering synchronous virtual care (live video-conferencing) for all Commercial plan designs
- Care not limited to COVID-19 issues
- “use telehealth as your first line of defense” in order to limit potential exposure

Aetna – Released March 25th

- **Aetna will waive member cost sharing for any covered telemedicine visits regardless of diagnosis - including mental health.** For commercial plans, cost sharing will be waived for all virtual visits through the Aetna-covered Teladoc[®] offerings and in-network providers delivering telemedicine services.
- Aetna is allowing clinicians to deliver **mental health counseling and consultative services through telemedicine** to members who are hospitalized.
- Reimbursing **Applied Behavioral Analysis delivered via televideo**, allowing children with Autism to receive therapy services at home with required professional oversight.
- **Reimbursing for Medication Assisted Treatment (MAT) services conducted through televideo or telephonically**
- **Aetna is also expanding coverage of telemedicine visits to its Aetna Medicare members,**
- **Aetna Employee Assistance Program counseling sessions** can be delivered via televideo or telephonically until June 4, 2020.
- **Patients won't have to pay a fee** for home delivery of prescription medications from CVS Pharmacy[®].
- **We're waiving early refill limits on 30-day prescription maintenance** medications for all Commercial members with pharmacy benefits administered through CVS Caremark.
- **Aetna Medicare members may request early refills on 90-day prescription maintenance medications**
- **Care packages will be sent to Aetna patients diagnosed with COVID-19.** Through

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Telehealth for medical providers

For Blue Cross[®] PPO (commercial), Medicare Plus BlueSM PPO,
BCN HMOSM (commercial) and BCN AdvantageSM members

March 23, 2020

Telehealth is an umbrella term that includes telemedicine, telephone and online visits which can be beneficial in reducing the need for in-person medical care. Seeking virtual consultations for mild flu-like symptoms is a safe step for members who want to talk with board-certified doctors and can help avoid the spread of illness in physician office and emergency room settings. **Not all contracts include coverage for telehealth.** Check your patient's benefits and encourage them to do the same through the BCBSM member app or bcbsm.com portal.

Definitions

Telemedicine is the use of telephone or telecommunications technology for real time clinical health care services provided through electronic technology when distance separates the patient and health care provider. The patient and health care provider are connected via a secure network.

****HIPAA compliance requirements for telehealth visits have been relaxed during the COVID-19 crisis to make it easier for providers to conduct health care visits remotely. Through April 30, 2020, we've aligned our requirements with the Centers for Medicare and Medicaid Services as outlined in their [Medicare Telemedicine Health Care Provider Fact Sheet](#). Prior to April 30, we will re-evaluate this temporary alignment, and if needed, extend it.**

We will accept non-secure telemedicine technologies such as Apple FaceTime, Facebook Messenger, Google Hangouts video or Skype until the end of April 2020 as long as both of these occur:

- You are actively working toward implementing a secure process
- You take responsibility for communicating the shortcomings of the process to the patient and proceed only if the patient accepts those shortcomings

Note that public-facing options are not acceptable. Facebook Live, Twitch and TikTok are examples of technologies that aren't acceptable.

MEDICARE TELEHEALTH VISITS:

Currently, Medicare patients may use telecommunication technology for office, hospital visits and other services that generally occur in-person. The provider must use an interactive audio and video telecommunications system



Billing Requirements

	Modifier GT or 95	Place of Service 02
Online Codes 98970-98972, 99421-99423	No	Yes
Telephone Codes 99441 – 99443 98966 – 98968	No	Yes
Crisis Codes (telephone) 90839 and 90840	Yes	Yes
CPT Codes (Appropriate for encounter and provider scope)	Yes	Yes

Billing Requirements Table

When care is delivered virtually (by telemedicine), the appropriate modifier and place of service must be billed.

1. When care is delivered through an online visit, and the appropriate CPT code is submitted, a place of service 02 should also be submitted. A modifier is not necessary.
2. When care is delivered using a secure telephone transmission, and the appropriate CPT code is submitted, a place of service 02 should also be submitted. A modifier is not necessary.
3. When care is delivered using a secure telephone transmission for crisis intervention, and the appropriate CPT code is submitted, a place of service 02 and the GT modifier should also be submitted. A modifier is needed because the nomenclature of the codes do not specify how the service is delivered.
4. When care is delivered using a secure audio and video transmission, and the appropriate CPT code to reflect the encounter is submitted, a place of service 02 and the GT modifier

Resources

Telehealth Visits

Synchronous audio/visual visit between a patient and clinician for evaluation and management (E&M)

Code	Description
CPT Code 99201-99205 POS 02 for Telehealth (Medicare) Modifier 95 (Commercial Payers)	Office or other outpatient visit for the evaluation and management of a new patient
CPT Code 99210-99215 POS 02 for Telehealth (Medicare) Modifier 95 (Commercial Payers)	Office or other outpatient visit for the evaluation and management of an established patient

*A list of all available codes for telehealth services can be found here:
<https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>

CODE	RVU	STATUS CODE
99201	1.29	A
99202	2.14	A
99203	3.03	A
99204	4.63	A
99205	5.85	A
99211	0.65	A
99212	1.28	A
99213	2.11	A
99214	3.06	A
99215	4.11	A

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Online Digital Visits

Digital visits and/or brief check-in services furnished using communication technology that are employed to evaluate whether or not an office visit is warranted (via patient portal, smartphone).

Code	Description
CPT Code 99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
CPT Code 99422	11-20 minutes
CPT Code 99423	21 or more minutes
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

CODE	RVU	STATUS CODE
99421	0.43	A
99422	0.86	A
99423	1.39	A
G2012	0.41	A
G2010	0.34	A

* CPT codes 98970-98971 were modified in 2020 to match the CMS language captured in HCPCS code G2061-G2063.

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Telephone Evaluation and Management Service

CPT codes to describe telephone evaluation and management services have been available since 2008. Relative values are assigned to these services. **Medicare still currently considers these codes to be non-covered.** However, private payors may pay for these services.

Code	Description
CPT Code 99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian 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
CPT Code 99442	11-20 minutes of medical discussion
CPT Code 99443	21-30 minutes of medical discussion

CODE	RVU	STATUS CODE
99441	0.40	N
99442	0.78	N
99443	1.14	N
Not Payable By Medicare (3-20-20)		

* The AMA is urging CMS to begin covering these services under Medicare immediately in light of the novel coronavirus emergency.

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Online Digital Visits

Digital visits and/or brief check-in services furnished using communication technology that are employed to evaluate whether or not an office visit is warranted (via patient portal, smartphone).

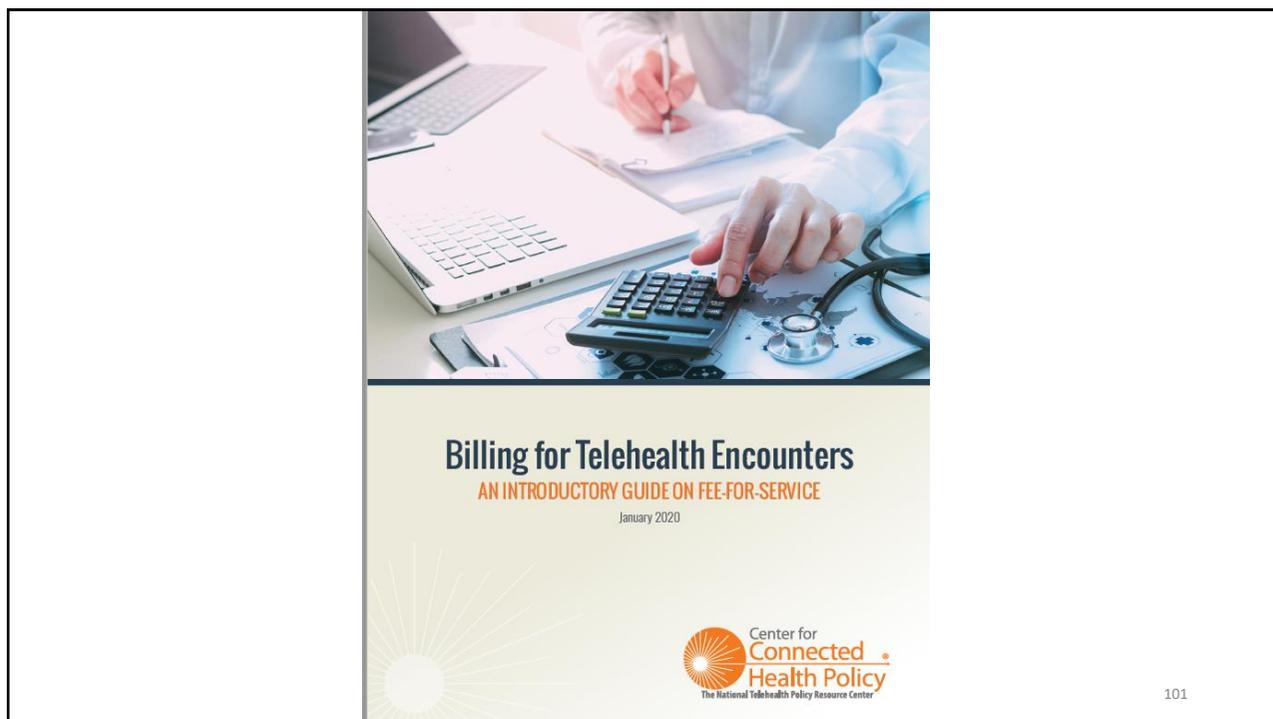
Code	Description
CPT Code 98970*	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
CPT Code 98971*	11-20 minutes
CPT Code 98972*	21 or more minutes
HCPCS Code G2061	Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes
HCPCS Code G2062	11-20 minutes
HCPCS Code G2063	21 or more minutes

* CPT codes 98970-98971 were modified in 2020 to match the CMS language captured in HCPCS code G2061-G2063.

CODE	RVU	STATUS CODE
98970	--	I
98971	--	I
98972	--	I
G2061	0.34	A
G2062	0.60	A
G2063	0.94	A

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• CCHPCA.org



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CMS Current Emergency Website

- <https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page>

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How we can help | Current emergencies | Providers, states & tribes | Get ready | Resources | Past emergencies

Current emergencies

Here's information and updates about natural disasters, man-made incidents, and public health emergencies that are happening now. Find more information on [ongoing](#) or [past emergencies](#).

2020

Coronavirus

When President Trump declared a national emergency on March 13, 2020, [CMS took action nationwide to aggressively respond to Coronavirus](#).

- You can read about the blanket waivers for COVID19 in the [Emergency Declaration Health Care Providers Fact Sheet \(PDF\)](#). (3/13/20)

Secretary Azar used his authority in the Public Health Service Act to declare a [public health emergency](#) (PHE) in the entire United States on January 31, 2020 giving us the flexibility to support our beneficiaries, effective January 27, 2020.

- [Coronavirus 1812\(f\) waiver \(PDF\)](#)
- [Florida Coronavirus 1135 waiver](#)

General information & updates:

- [Coronavirus.gov](#) is the source for the latest information about COVID-19 prevention, symptoms, and answers to common questions.
- [USA.gov](#) has the latest information about what the U.S. Government is doing in response to COVID-19.

Press releases:

- Secretary Azar's [PHE declaration press release](#) (1/31/20)
- Our press releases:

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Press releases:

- Secretary Azar's [PHE declaration press release](#) (1/31/20)
- Our press releases:
 - [CMS Sends Guidance to Programs of All-Inclusive Care for the Elderly \(PACE\) Organizations](#) (3/17/20)
 - [President Trump Expands Telehealth Benefits for Medicare Beneficiaries During COVID-19 Outbreak](#) (3/17/20)
 - [CMS Approves First State Request for 1135 Medicaid Waiver in Florida](#) (3/17/20)
 - [CMS Announces New Measures to Protect Nursing Home Residents from COVID-19](#) (3/13/20)
 - [Emergency Declaration Press Call Remarks by CMS Administrator Seema Verma](#) (3/13/20)
 - [CMS takes Action Nationwide to Aggressively Respond to Coronavirus National Emergency](#) (3/13/20)
 - [CMS Publishes FAQs to Ensure Individuals, Issuers, and States have Clear Information on Coverage Benefits for COVID-19](#) (3/13/20)
 - [CMS Issues Frequently Asked Questions \(FAQs\) to Aid State Medicaid and Children's Health Insurance Program \(CHIP\) Agencies in Their Response to the 2019 Novel Coronavirus \(COVID-19\) Outbreak](#) (3/12/20)
 - [CMS issues Frequently Asked Questions on Guidance to State Survey Agencies Suspending Non-Emergency Survey Inspections](#) (3/10/20)
 - [CMS Issues Key Protective Mask Guidance for Healthcare Workers](#) (3/10/20)
 - [CMS Sends More Detailed Guidance to Providers about COVID-19](#) (3/10/20)
 - [CMS Issues Guidance to help Medicare Advantage and Part D Plans Respond to COVID-19](#) (3/10/20)
 - [CMS Issues Call to Action for Hospital Emergency Departments to Screen Patients for Coronavirus](#) (3/9/20)
 - [CMS Issues Clear Actionable Guidance to Providers about COVID-19 Virus](#) (3/9/20)
 - [Telehealth Benefits in Medicare are a Lifeline for Patients During Coronavirus Outbreak](#) (3/9/20)
 - [COVID-19 Response News Alert: CMS Issues Frequently Asked Questions to Assist Medicare Providers](#) (3/6/20)
 - [CMS Develops Additional Code for Coronavirus Lab Tests](#) (3/5/20)
 - [CMS COVID-19 Response News Alerts: Press Release: CMS Announces Actions to Address Spread of Coronavirus](#) (3/4/20)
 - [Public Health News Alert: CMS Develops New Code for Coronavirus Lab Test](#) (2/13/20)
 - [CMS Prepares Nation's Healthcare Facilities for Coronavirus Threat](#) (2/6/20)

Clinical & technical guidance:

For health care facilities

- [Guidance for Infection Control and Prevention of Coronavirus Disease 2019 \(COVID-19\) in Nursing Homes-REVISED \(PDF\)](#) (3/13/20)
- [Guidance for Use of Certain Industrial Respirators by Health Care Personnel](#) (3/10/20)
- [Guidance for Infection Control and Prevention Concerning Coronavirus Disease 2019 \(COVID-19\) in Home Health Agencies](#) (3/10/20)
- [Guidance for Infection Control and Prevention Concerning Coronavirus Disease 2019 \(COVID-19\) in Survey Facilities](#) (3/10/20)

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THANK YOU !!

And now it is time for your questions



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RESOURCES



AOA Covid-19 Resources

www.osteopathic.org/covid-19

AOIA Webinars

<https://aoaonlinelearning.osteopathic.org/course/index.php?categoryid=40>

Telemedicine Platforms

Remote Monitoring of COVID-19 Patients

Ceras Health – <https://cerashealth.com/aoa.html> - 877-723-7277

Patients download the Ceras app and enter vitals three times a day. Readings are monitored by a Ceras RN. If the readings raise an alert, Ceras will notify the patient and provider for follow up. Consult with Ceras on your state reimbursement. No implementation fee for AOA members

Free COVID video consultations

Bluestream Health is offering AOA members free access to HIPAA-compliant video sessions with patients during the COVID-19 crisis. Bluestream will create a platform for the provider to send a secure invite to your patient via text or email. The patient clicks on the link to begin a HIPAA-compliant video session with provider. Email membervalue@osteopathic.org to receive the link.

Find links at osteopathic.org/membervalue

Questions? membervalue@osteopathic.org

Questions & Answers

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Physician Services Department
1-312-202-8194
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THANK YOU

