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Dear Jose Luis,

Welcome to the front lines of a full-on health crisis! Fortunately, community has not been hit as hard as many others. I am grateful that. Yet, most of all, I'm worried for our cancer patients. Many are immunologically compromised and are struggling without COVID. This must be so hard on them, fighting on two health fronts at on

One thing [we might see this week is some change in the telehealth laws](#), which even the Administrator of Medicare, Seema Verma, has said are outdated. It would be good to get fully paid for patients dialing in remotely. See our first article for coding and billing for COVID-19 services and billing for patients at home under the current regulations. Once these change, we will dispatch an update.

Of course, the march of other rules and regulations continues. The Medicare interoperability laws changed recently and we have them on you. This law mostly impacts EHR vendors and hospitals. Some provisions of this law may be folded into 2021 MIPS.

Also, we tell you what's up with HCPCS. There are no new J-code Q-codes issued for April 1, 2020. Why? Check out our article. Sometimes, I wonder what they are thinking in DC.

We also have an article on Advance Care Planning. It is a good one to read while you are Social Distancing; or, while you are wishing that bars were still open. We are not suggesting the usual place for reading this newsletter due to the shortage of toilet paper....

Lastly, please take care of yourselves. I am not a praying person, but if I was, I would be praying that 100% of the people reading this newsletter will be reading it next month and the month after that and so on...STAY SAFE!!!****

Da' Mistress

Corona Billing, Coding, and Coverage Guidelines

There are codes that have been developed for Corona Virus, also known as COVID-19. I like to call it Corona because it reminds of al and fun, rather than the Dystopian reality in which we currently reside. here we attempt to outline ICD-10-CM codes that can be used; the HCPCS codes developed for testing (when they are available); and some suggestions on how to bill for patients at home. CMS has b making exaggerated claims that they have changed their telehealth po They have not, but they actually do have the discretion to now that the a national emergency. We shall see.

ICD-10-CM Codes

Please be aware that these [guidelines come directly from the Centers Disease Control](#). This is called "Interim Guidance", meaning that it is subject to change and we will update you as the situation develops. S here goes--I hope this is helpful.

- **Signs and symptoms:** For patients presenting with any signs/symptoms (such as fever, etc.) and **where a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms such as:**
 - R05 Cough
 - R06.02 Shortness of breath
 - R50.9 Fever, unspecified
- **COVID-19 Confirmed cases with manifestations: The code the coronavirus is B97.29 (other coronavirus as the cause diseases classified elsewhere).** The words "diseases classified elsewhere" means the other disease is used in the first position the claim form. **The CDC specifically says not to use B34.2 (coronavirus infection unspecified)** because the known cases have all been respiratory in nature and B34.2 is *unspecified*. S bottom line--code the respiratory manifestation as we show in the examples below
 - Pneumonia For a pneumonia case confirmed as due to 2019 novel coronavirus (COVID-19), **assign codes J12 Other viral pneumonia, and B97.29, Other coronavirus as the cause of diseases classified elsewhere.**
 - Acute bronchitis: For a patient with acute bronchitis confirmed as due to COVID-19, **assign codes J20.8, Acute bronchitis due to other specified organisms, and B97.29. If the bronchitis is not specified as acute due to COVID-19, report code J40, Bronchitis, not specified as acute or chronic, along with code B97.29.**
 - Lower respiratory infection: If the COVID-19 is documented as being associated with a lower respiratory infection, not otherwise specified (NOS), or **an acute respiratory infection, NOS, report with code J22, Unspecified acute lower respiratory infection, with code B97.29.** If the COVID-19 is **documented as being associated with a respiratory infection, NOS, it would be appropriate to assign code J98.8, Other specified respiratory disorder with code B97.29.**
 - Acute respiratory distress syndrome (ARDS): ARDS may develop in conjunction with COVID-19. Cases with **ARD due to COVID-19 should be assigned the codes J80, Acute respiratory distress syndrome, and B97.29.**
- **If the provider documents "suspected", "possible" or "probable" COVID-19, do not assign code B97.29. Assign a code(s) explaining the reason for encounter (such as fever Z20.828. Contact or suspected exposure to a communicable disease agent).**

disease).

- **If the patient has exposure to Corona but is not symptomatic there are two ways this can be coded.**
 - **For cases where there is a concern about a possible exposure to COVID-19, but this is ruled out after evaluation,** it would be appropriate to assign the code Z03.818, Encounter for observation for suspected exposure to other biological agents ruled out.
 - **For cases where there is an actual exposure to someone who is confirmed to have COVID-19, it would be appropriate to assign the code Z20.828, Contact with (suspected) exposure to other viral communicable disease.**

CPT/HCPCS Coding

To empower surveillance and laboratory testing in response to the spread of the novel coronavirus (SARS-CoV-2), [the American Medical Association \(AMA\) announced](#) a unique Current Procedural Terminology (CPT®) code for reporting novel coronavirus tests will be considered at a special CPT Editorial Panel meeting last week. If approved, **the new CPT code will support the response to the urgent public health need for streamlined reporting of novel coronavirus testing offered by hospitals, health systems and laboratories in the United States.** Keep you posted on this.

In another development, CMS [recently announced](#) the development of **new billing codes for corona virus lab tests** that will enable clinical laboratories and other providers to receive reimbursement for support patients during the outbreak and help increase testing and tracking of cases. CMS also announced that Medicare Part B would cover a test to determine if beneficiaries have coronavirus for dates of service on or after Feb. 4, 2020. **But providers of the test will have to wait until after Jan. 1, 2020, to submit a claim to Medicare for the test.** These codes are as follows:

- U0001 is for SARS-CoV-2 diagnostic tests performed specifically at CDC testing laboratories
- U0002 is the second billing code released last Thursday will expand medical billing and coding for coronavirus lab tests, permitting laboratories to bill for non-CDC laboratory tests for SARS-CoV-2/2019-nCoV, otherwise known as the novel coronavirus or COVID-19.
- As necessary, check to see

Keeping Patients Out of the Office

The telehealth rules for Medicare (as completely silly as they are) will be waived at the discretion of Secretary Azar. Legally, this can be changed when the Administration declares a National Emergency for the country (which they have done) or in specific geographical areas. **The problem is this waiver and the rules around some telehealth codes are for ESTABLISHED Patients. The Pelosi-Mnuchin Bill changes that, but it is not passed. Until the rules change in your area or for all of us,** you can use the CPT remote codes which include G2000-G2003 for Technology-Based Patient Check in; 99421-99423 for Online Digital Assessment Services; G2061-G2063 for On-line Digital Assessment Services by NPs and PAs who do not have E/M in their scope of practice; and 99446-99452 for Telephone/Internet/ EHR Consultations. Make sure you read the documentation requirements and restrictions on each code set. **Check your private payers including Medicare Advantage for their guidelines on telehealth. Medicare Advantage cost-sharing requirements have been waived for COVID-19 related tests.**

Here are Medicare's [Frequently Asked Questions about COVID-19](#).

Interoperability Rule Finalized

Last week, [the Centers for Medicare and Medicaid Services \(CMS\) and the Office of the National Coordinator for Health IT \(ONC\)](#) released the final rules for Information Interoperability. Payer and provider organizations say HHS' timelines to implement interoperability regulations are "troubling" and its tight timelines are not realistic given the current evolving pandemic. Fortunately, for cancer practices and outpatient clinics, most of these regulations will not directly impact you this year. But, they will affect your patients along with payers and hospitals.

Officials said the rules likely will give patients a greater say in health care decisions and put an end to a long-standing practice in which some doctors and hospitals resist handing complete medical file over to patients upon demand, known as information "blocking". Most of the provisions are set to take effect in 2022.

The overarching goal of these rules is to advance patients' access to their health information through mobile apps, despite concern from some EHR vendors regarding privacy. The details are outlined in the new rules from the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health IT (ONC).

The rules also attempt to prevent EHR vendors from silencing critics of their software products. The government wants to encourage doctors and other users of EHR technology to share their experiences about software problems by prohibiting so-called gag clauses in sales contracts. That could free users to criticize EHR systems, including more open discussion of flaws, software glitches and other breakdowns.

[CMS' Interoperability and Patient Access final rule](#) will require, among other things, that **Medicaid, the Children's Health Insurance Program (CHIP), Medicare Advantage (MA) plans and qualified health plans (not providers) make enrollee data immediately accessible and do so within nine months**, by January 2021. Insurance Plans will have to do this by developing a secure, standards-based (HL7 FHIR Release 4.0.1) API that **allows patients to easily access their claims and encounter information, including cost, through a third-party app of their choice.** Let's all remember that payers are certainly not used to these kinds of regulatory deadlines, particularly for Information Technology.

As part of the [CMS rule](#), **hospitals will have to begin doing patient "event" notifications in about six months.** CMS has said the policy goes into effect six months after publication of the rule, which may take several days or weeks. **Those electronic admission, discharge and transfer (ADT) notifications will be required as a condition of participation in Medicare, per the rule. Conditions of participation govern a hospital's access to Medicare and Medicaid funding.**

Hospital groups are concerned that [ONC is maintaining a two-year implementation timeline](#) for updates to electronic health records (EHR) APIs from the provider side. **As part of its interoperability and information blocking rule, ONC is requiring vendor development and provider adoption all within a two-year window. This is a whole lot to get done within a relatively short time frame.**

HCPCS: What the Heck??

Wonder why there are **NO NEW J-codes or Q-codes for April 1, 2020**?? Right here, you can see that the only new codes added for dates of service are C-codes. Why is that? Are there no new drugs?? Yes, Virginia, there are new drugs, but there is a new procedure. We do not know the date of the new procedure, but manufacturers have told me that they are facing delays because they did not comply with either the new deadlines and/or application procedures.

The Centers for Medicare & Medicaid Services (CMS) updated its Healthcare Common Procedural Coding System (HCPCS) Level II code procedures to enable shorter and more frequent HCPCS code application cycles. How's that working out?

Beginning in January 2020, CMS officially implemented quarterly HCPCS code applications for drugs and biological products; and annual application opportunities for durable medical equipment, orthotics, prosthetics and supplies, and other non-drug, non-biological products. As announced informally in May by CMS Administrator Seema Verma, this change is part of CMS' broader, comprehensive initiative to foster innovation and get new products paid faster. Here are the deadlines for drugs and biologicals:

- **First quarterly cycle application deadline: 4:00 PM January 2020**
- **Second quarterly cycle application deadline: 4:00 PM April 2020**
- **Third quarterly cycle application deadline: 4:00 PM June 21, 2020**
- **Fourth quarterly cycle application deadline: 4:00 PM September 21, 2020**

CMS has released two documents containing detailed information pertaining to our updated HCPCS Level II Coding procedures, application instructions, and deadlines for 2020, titled: [Healthcare Common Procedure Coding System \(HCPCS\) Level II Coding Procedures](#), and [Healthcare Common Procedure Coding System \(HCPCS\) Level II Code Modification Application Instructions for the 2020 Coding Cycle](#)

Publication of HCPCS Decisions

Two additional companion documents to the Annual Update are available on [CMS HCPCS web site](#): 1) "CMS' Level II HCPCS Coding Decision: the 2019-2020 Coding Cycle", which is a spreadsheet including a sequential listing of CMS' code applications, statement of request, CMV Preliminary HCPCS coding recommendation, and CMS' Final HCPCS coding recommendation; and 2) a series of five narrative summary documents, one for each of the five HCPCS public meetings held in 2019. These summary documents include a narrative about each application capturing the request topic and background summary, preliminary HCPCS coding recommendation, a summary of primary speaker comments, and CMS' final HCPCS coding decision.

Changes in Notification Procedure

As part of CMS' ongoing efforts to improve transparency regarding the Healthcare Common Procedure Coding System (HCPCS) coding decisions and streamline its processes, CMS is implementing additional improvements to the issuance of HCPCS coding decisions.

Historically, CMS publishes the HCPCS Annual Update on CMS' HCPCS

Historically, CMS publishes the HCPCS Annual Update on CMS' HCPCS web site and also mailed written decision letters to individual applicants. In 2014, CMS began publishing a spreadsheet with the prior years of Level I coding decisions at the end of the coding cycle. In 2017, CMS added narrative statements for the prior years of Level II coding decisions, which provide additional detailed information, including the topic and background summary of every application; CMS' published preliminary HCPCS code recommendations; a summary of Primary Speaker comments at CMS' HCPCS Public Meeting; and CMS' final coding decisions. CMS received positive feedback from stakeholders regarding making this detailed information publicly available, along with requests to retain prior year coding information on our web site and add subsequent coding information toward development of a cumulative resource, instead of publishing current cycle information only. Accordingly, in early 2019, CMS created an intuitive online search feature to identify links to current and prior year publications, and restored previously published information from prior years.

Typically, the information in the narrative summary has also been included in HCPCS coding decision letters written by CMS and mailed to each individual applicant. **To streamline notification processes, effective 2019-2020 HCPCS coding cycle, rather than issuing individual decision letters, CMS refers applicants and other stakeholders to narrative summary and "Healthcare Common Procedure Coding System (HCPCS) Level II Coding Procedures" documents [published on the web site](#).**

Advance Care Planning: Are You Billing It?

If you are a Cancer Practice or Clinic, the question should be why are you billing it?? The answers could be herein. Check it out!

The American Medical Association's *CPT Assistant* (December 2016) describes Advance Care Planning (ACP) as "learning about and considering the types of decisions that will need to be made at the time of an eventual life-ending situation and what the patient's preferences would be regarding those decisions."

According to *CPT Assistant* (February 2016), factors under consideration may include:

- the patient's current disease state
- disease progression
- available treatments
- cardiopulmonary resuscitation/ life sustaining measures,
- do not resuscitate orders
- life expectancy based on the patient's age and co-morbidities
- clinical recommendations of the treating physician, including reviews of patient's past medical history and medical documentation/reports, and
- response(s) to previous treatments

CPT lists two codes to describe time spent with a patient, family member, or surrogate discussing advanced directives, medical orders for life-sustaining treatment, living wills, or similar advance care planning. These codes, which have been around since 2014 are

- 99497 Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified healthcare professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

- face with the patient, family member(s), and/or surrogate
- 99498 ... each additional 30 minutes (List separately in addition to code for primary procedure)

Code 99497 describes an initial 30 minutes of the providers' time (face-to-face with the patient, family, or surrogate). You should report only one unit of 99497, per date of service (that's the MUE). Many physicians find this 30-minute time requirement arduous. Code 99498 reports each additional 30-minutes of service, beyond the initial 30 minutes (at least 16 minutes must pass beyond the initial 30 minutes to report 99498). For example, for 35 minutes of face-to-face ACP, proper coding is 99497; for 55 minutes of face-to-face advance care planning proper coding is 99497, 99498.

Because these services are time-based, the provider must document the face-to-face time spent with the patient, family member, or other caregiver. Best practices are noting start and stop times (just like drug administration), total face-to-face time, a summary of the points discussed, and other relevant details such as the prospective patient's response or decisions related to future treatment. The codes account only for the provider's time and expertise, and do not include active management of a problem(s).

ACP may be provided and reported on the same day, or a different day, as other evaluation and management (E/M) service. A list of E/M codes with which you may report 99497 and 99498 is included in the CPT guidelines preceding the code listings. Per CPT instruction, do not report advanced care planning on the same date of service as 99291, 99292, 99468, 99469, 99471, 99472, 99475, 99476, 99477, 99478, 99479, or 99480 (e.g., any critical care service).

As far as Advance Care Planning is concerned with chemo or other drug administration, the CCI edit states: both code 99497 and the codes below would be reimbursed for the same beneficiary on the same day when performed by the same provider, if submitted with the appropriate modifier. We suggest Modifier -25. Other services that require a Modifier include hospital and observation: 99221-99223, 99220, 99224-99226, 99234-99236. Radiation has many CCI edits. Check with the individual service.

Medicare will cover ACP as a separate service, or as an optional element (at the beneficiary's discretion) of the Initial Preventive Physical Examination (IPPE), or "Welcome to Medicare" exam, and of the Medicare Annual Wellness Exam. CMS stresses that ACP services are voluntary and that Medicare beneficiaries (or their legal proxies) "should be given clear opportunity to decline to receive ACP services."

Per CPT, there are no limits on the number of times ACP can be reported for a given beneficiary in a given time period. Likewise, the Centers for Medicare & Medicaid Services has not established any frequency limit over time. **When the service is billed multiple times for a given beneficiary, CMS says: "We would expect to see a documented change in the beneficiary's health status and/or wishes regarding or her end-of-life care."**

CMS does not have place-of-service restrictions on ACP: The services may be reported in both office, outpatient, and inpatient settings.

CMS does not limit ACP services to particular physician specialties. The ACP services described by these codes, according to CMS, are prima

the provenance of patients and physicians. **The usual Medicare payment rules regarding "incident to" services apply, so that when the services are furnished incident to the billing physician or practitioner all applicable state law and scope of practice requirements must be met and there must be a minimum of direct supervision in addition to other incident to rules.**

Some references used in this article include the following:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf>

<https://www.aafp.org/news/practice-professional-issues/20160525faqadvcare.html>

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5144846/>

<https://www.physicianspractice.com/coding/coding-advance-care-planning/page/0/1>

Remember this newsletter is a summary of regulations for Medical Oncology. It is a preliminary reading of complex coding and billing material. There may be typos and misinterpretations. Providers are responsible for the information on every claim. Payers have differing rules and interpretations thereof. Reading this newsletter does not substitute understanding regulations and verifying the validity of every claim. This information is time-sensitive and is subject to constant change. onPoint Oncology Incorporated and/or its partners/founders accepts no liability for any statements or articles herein. Statistics given herein are valid for the date of report only.

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Sincerely,

Da' Mistress of All She Surveys

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