



## Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)

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**Note: We revised this article on April 10, 2020, to:**

- **Link to all the blanket waivers related to COVID-19**
- **Provide place of service coding guidance for telehealth claims**
- **Link to the Telehealth Video for COVID-19**
- **Add information on the waiver of coinsurance and deductibles for certain testing and related services**
- **Add information on the expanded use of ambulance origin/destination modifiers**
- **Provide new specimen collection codes for clinical diagnostic laboratories billing**
- **Add guidance regarding delivering notices to beneficiaries.**

**All other information is the same.**

### PROVIDER TYPES AFFECTED

This MLN Matters® Special Edition Article is for providers and suppliers who bill Medicare Fee-For-Service (FFS).

### PROVIDER INFORMATION AVAILABLE

The Secretary of the Department of Health & Human Services declared a public health emergency (PHE) in the entire United States on January 31, 2020. On March 13, 2020 Secretary Azar authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to March 1, 2020.

The Centers for Medicare & Medicaid Services (CMS) is issuing blanket waivers consistent with those issued for past PHE declarations. These waivers prevent gaps in access to care for beneficiaries impacted by the emergency. You do not need to apply for an individual waiver if a blanket waiver is issued.

More Information:

- [Coronavirus Waivers and Flexibilities](#) webpage
- [Instructions](#) to request an individual waiver if there is no blanket waiver

## BACKGROUND

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### ***Section 1135 and Section 1812(f) Waivers***

As a result of this PHE, apply the following to claims for which Medicare payment is based on a “formal waiver” including, but not limited to, Section 1135 or Section 1812(f) of the Act:

1. The “DR” (disaster related) condition code for institutional billing, i.e., claims submitted using the ASC X12 837 institutional claims format or paper Form CMS-1450.
2. The “CR” (catastrophe/disaster related) modifier for Part B billing, both institutional and non-institutional, i.e., claims submitted using the ASC X12 837 professional claim format or paper Form CMS-1500 or, for pharmacies, in the NCPDP format.

Medicare FFS Questions & Answers (FAQs) available on the [Waivers and Flexibilities webpage](#) apply to items and services for Medicare beneficiaries in the current emergency. These FAQs are displayed in these files:

- [COVID-19 FAQs](#)
- FAQs that apply [without any Section 1135](#) or other formal waiver.
- FAQs apply only [with a Section 1135](#) waiver or, when applicable, a Section 1812(f) waiver.

### ***Blanket Waivers Issued by CMS***

View the [complete list](#) of COVID-19 blanket waivers.

### **Billing for Professional Telehealth Distant Site Services During the Public Health Emergency**

CMS is expanding this benefit on a temporary and emergency basis under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act.

View a [complete list](#) of services payable under the Medicare Physician Fee Schedule when furnished via telehealth.

When billing professional claims for all telehealth services with dates of services on or after March 1, 2020, and for the duration of the PHE, bill with:

- Place of Service (POS) equal to what it would have been had the service been furnished in-person
- Modifier 95, indicating that the service rendered was actually performed via telehealth

As a reminder, CMS is not requiring the CR modifier on telehealth services. However, consistent with current rules for telehealth services, there are two scenarios where modifiers are required on Medicare telehealth professional claims:

- Furnished as part of a federal telemedicine demonstration project in Alaska and Hawaii using asynchronous (store and forward) technology, use GQ modifier
- Furnished for diagnosis and treatment of an acute stroke, use G0 modifier

There are no billing changes for institutional claims; critical access hospital method II claims should continue to bill with modifier GT.

CMS released a video providing answers to common questions about the Medicare telehealth services benefit.

[Video](#)

### **Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Additional COVID-19 Related Services**

The Families First Coronavirus Response Act waives cost-sharing under Medicare Part B (coinsurance and deductible amounts) for Medicare patients for COVID-19 testing-related services. These services are medical visits for the HCPCS evaluation and management categories described below when an outpatient provider, physician, or other providers and suppliers that bill Medicare for Part B services orders or administers COVID-19 lab test U0001, U0002, or 87635.

Cost-sharing does not apply for COVID-19 testing-related services, which are medical visits that: are furnished between March 18, 2020 and the end of the PHE; that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test; and are in any of the following categories of HCPCS evaluation and management codes:

- Office and other outpatient services
- Hospital observation services
- Emergency department services
- Nursing facility services
- Domiciliary, rest home, or custodial care services
- Home services
- Online digital evaluation and management services

Cost-sharing does not apply to the above medical visit services for which payment is made to:

- Hospital Outpatient Departments paid under the Outpatient Prospective Payment System
- Physicians and other professionals under the Physician Fee Schedule
- Critical Access Hospitals (CAHs)
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)

Previously, CMS made available the CS modifier for the gulf oil spill in 2010; however, CMS recently repurposed the CS modifier for COVID-19 purposes. Now, for services furnished on March 18, 2020, and through the end of the PHE, outpatient providers, physicians, and other providers and suppliers that bill Medicare for Part B services under these payment systems should use the CS modifier on applicable claim lines to identify the service as subject to the cost-sharing waiver for COVID-19 testing-related services and should NOT charge Medicare patients any co-insurance and/or deductible amounts for those services.

### **COVID-19: Expanded Use of Ambulance Origin/Destination Modifiers**

During the COVID-19 PHE, Medicare will cover a medically necessary emergency and non-emergency ground ambulance transportation from any point of origin to a destination that is equipped to treat the condition of the patient consistent with state and local Emergency Medical Services (EMS) protocols where the services will be furnished. On an interim basis, we are expanding the list of destinations that may include but are not limited to:

- Any location that is an alternative site determined to be part of a hospital, Critical Access Hospital (CAH), or Skilled Nursing Facility (SNF)
- Community mental health centers
- Federally Qualified Health Centers (FQHCs)
- Rural health clinics (RHCs)
- Physicians' offices
- Urgent care facilities
- Ambulatory Surgery Centers (ASCs)
- Any location furnishing dialysis services outside of an End-Stage Renal Disease (ESRD) facility when an ESRD facility is not available
- Beneficiary's home

CMS expanded the descriptions for these origin and destination claim modifiers to account for the new covered locations:

- Modifier D - Community mental health center, FQHC, RHC, urgent care facility, non-provider-based ASC or freestanding emergency center, location furnishing dialysis services and not affiliated with ESRD facility
- Modifier E – Residential, domiciliary, custodial facility (other than 1819 facility) if the facility is the beneficiary's home
- Modifier H - Alternative care site for hospital, including CAH, provider-based ASC, or freestanding emergency center
- Modifier N - Alternative care site for SNF
- Modifier P - Physician's office
- Modifier R - Beneficiary's home

For the complete list of ambulance origin and destination claim modifiers see [Medicare Claims Processing Manual Chapter 15](#), Section 30 A.

### **New Specimen Collection Codes for Laboratories Billing for COVID-19 Testing**

To identify and reimburse specimen collection for COVID-19 testing, CMS established two Level II HCPCS codes, effective with line item date of service on or after March 1, 2020:

- G2023 - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source
- G2024 - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source

These codes are billable by clinical diagnostic laboratories.

### **Beneficiary Notice Delivery Guidance in Light of COVID-19**

If you are treating a patient with suspected or confirmed COVID-19, CMS encourages the provider community to be diligent and safe while issuing the following beneficiary notices to beneficiaries receiving institutional care:

- Important Message from Medicare (IM)\_CMS-10065
- Detailed Notices of Discharge (DND)\_CMS-10066
- Notice of Medicare Non-Coverage (NOMNC)\_CMS-10123
- Detailed Explanation of Non-Coverage (DENC)\_CMS-10124
- Medicare Outpatient Observation Notice (MOON)\_CMS-10611
- Advance Beneficiary Notice of Non-Coverage (ABN)\_CMS-R-131
- Skilled Nursing Advance Beneficiary Notice of Non-Coverage (SNFABN)\_CMS-10055
- Hospital Issued Notices of Non-Coverage (HINN)

In light of concerns related to COVID-19, current notice delivery instructions provide flexibilities for delivering notices to beneficiaries in isolation. These procedures include:

- Hard copies of notices may be dropped off with a beneficiary by any hospital worker able to enter a room safely. A contact phone number should be provided for a beneficiary to ask questions about the notice, if the individual delivering the notice is unable to do so. If a hard copy of the notice cannot be dropped off, notices to beneficiaries may also be delivered via email, if a beneficiary has access in the isolation room. The notices should be annotated with the circumstances of the delivery, including the person delivering the notice, and when and to where the email was sent.
- Notice delivery may be made via telephone or secure email to beneficiary representatives who are offsite. The notices should be annotated with the circumstances of the delivery, including the person delivering the notice via telephone, and the time of the call, or when and to where the email was sent.

We encourage the provider community to review all of the specifics of notice delivery, as set forth in Chapter 30 of the Medicare Claims Processing Manual at <https://www.cms.gov/media/137111>.

## ADDITIONAL INFORMATION

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The complete list of COVID-19 blanket waivers is available at <https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>.

Review information on the current emergencies webpage at <https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page>.

If you have questions, your MACs may have more information. Find their website at <http://go.cms.gov/MAC-website-list>.

Providers may also want to view the Survey and Certification Frequently Asked Questions at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html>.

## DOCUMENT HISTORY

Date of Change	Description
April 10, 2020	<p>Note: We revised this article to:</p> <ul style="list-style-type: none"> <li>• Link to all the blanket waivers related to COVID-19</li> <li>• Provide place of service coding guidance for telehealth claims</li> <li>• Link to the Telehealth Video for COVID-19</li> <li>• Add information on the waiver of coinsurance and deductibles for certain testing and related services</li> <li>• Add information on the expanded use of ambulance origin/destination modifiers</li> <li>• Provide new specimen collection codes for clinical diagnostic laboratories billing</li> <li>• Add guidance regarding delivering notices to beneficiaries.</li> </ul> <p>All other information is the same.</p>
March 20, 2020	We revised the article to add a note in the Telehealth section to cover the use of modifiers on telehealth claims and to explain the DR condition code is not needed on telehealth claims under the waiver. All other information is the same.
March 19, 2020	We corrected a typo in the article. One of the e-visit codes was incorrectly stated as 99431 and we corrected it to show 99421.
March 18, 2020	We revised this article to include information about the Telehealth waiver. All other information remains the same.
March 16, 2020	Initial article released.

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