Provider Relations Newsletter

April, 2020

This document is effective 4/17/2020 and is subject to revisions based on the rapidly changing environment.

NATIONAL CLAIMS ADMINISTRATION

COVID-19: Claims Processing FAQ for Providers | V9, Updated as of 4/17/2020; 4:30 pm PST

1. **Will Kaiser Permanente continue to accept and process claims submitted during the COVID-19 pandemic?**

   Yes. Kaiser Permanente will continue to accept and process claims according to the guidelines and processes found within our provider manual.

2. **Do you expect COVID-19 to impact Kaiser Permanente Claims Administration business operations? Is there risk of claims payments being delayed?**

   No, Kaiser Permanente's Claims Administration department is fully operational, and we do not anticipate any delays at this time. We have robust business continuity plans in place to ensure we meet claims timeliness requirements, and should anything change unexpectedly, we will keep providers and regulators informed about any anticipated delays.

3. **Will timely filing requirements for claims be waived, if providers' claims submissions are delayed due to impacts from COVID-19?**

   Kaiser Permanente will continue to apply all timely filing requirements, except where regulators have issued orders suspending or modifying the requirements. This policy may be revised or updated, as appropriate, based on the rapidly changing environment.

4. **Will claims be held if they have a COVID-19 diagnosis?**

   No, they will not be held. They will be processed according to our standard processing guidelines.

5. **Will Kaiser Permanente waive the requirement for authorization for some or all claims in light of COVID-19?**

   At this time, Kaiser Permanente is only waiving authorization for claims related to testing and screening of COVID-19. We will continue to apply all other authorization requirements, except where regulators have issued orders suspending or modifying the requirements. This policy may be revised or updated, as appropriate, based on the rapidly changing environment.

6. **Should providers collect cost sharing for COVID-19 screening, diagnosis, testing, or treatment services from our members?**

   Please do not collect cost sharing for COVID-19 screening, diagnosis, testing or treatment services from our members. Please refer to the COVID-19 coding information provided to you in a recent provider letter.

   The cost share waiver for screening and testing is effective March 5th, 2020 and the treatment waiver will apply for all dates of service (admissions) from April 1 through May 31, 2020, unless superseded by government action or extended by Kaiser Permanente.

7. **What diagnosis do the providers/groups use for Non COVID-19 related issues?**

   Providers should continue to follow standard ICD-10 coding guidelines for any non COVID-19-related issues.

8. **Can providers submit claims for authorized office visits that were converted to telehealth visits?**

   We appreciate your efforts to limit the spread of COVID-19 in the community. You may convert authorized office visits to telehealth visits, where clinically appropriate and technology is available, without seeking additional authorization from Kaiser Permanente.

   Please ensure that you request a visual verification of members' Kaiser Permanente Identification Cards during telehealth visits, just as you would in-person in your medical office setting.

   All members (Commercial, Individual and Family, Medicare and Medicaid) are covered for telehealth visits. While most members receive no-charge for telehealth visits, please use Online Affiliate to confirm the cost sharing for High Deductible Health Plan/HSA-qualified members who must first meet their deductible for telehealth visits unrelated to COVID-19 diagnosis and testing.

   Kaiser Permanente will follow Medicare rules regarding telehealth visits, as outlined in the enclosed attachment: "Medicare Telehealth Frequently Asked Questions," dated March 17, 2020.

   Reimbursement for telehealth visits will follow regulatory guidelines. For eligible telehealth visits, please use the appropriate Modifier "95" when submitting your professional (CMS) claims for these visits.

9. **Will providers have an alternative solution for submission of requested documents for claims payments or will Kaiser Permanente be waiving the requirement to submit requested documents during this time?**

   No, we will not be waiving the requirement to submit required requested documentation for claims, except where regulators have suspended or modified applicable rules. Should providers be unable to submit requested documentation, the claim will be denied. If claim is denied for lack of requested information, providers will still have an opportunity to re-file and submit the requested information to Kaiser Permanente within the timely filing period.

   Providers should continue to mail all requested documents to National Claims Administration. If you have questions concerning this topic, please email NW-Provider-Relations@kp.org.

10. Will providers be able to submit disputes or appeals online during this time?

Providers should continue to submit appeals and disputes online via Community Provider Connect (CPC) Portal.

11. What is the status of the temporary suspension of "Medicare Sequestration" under the CARES Act from May 1, 2020 through December 31, 2020?

The CARES Act: Sec. 3709. Adjustment of Sequestration 2020 states that during the period beginning on May 1, 2020 and ending on December 31, 2020, the Medicare programs under title XVII of the Social Security Act (42 U.S.C. 1395 et seq.) shall be exempt from any reduction under any sequestration order issued before, on, or after the date of enactment of this Act.

Kaiser Permanente will remove the 2% reduction in accordance with this ruling during the period of time this suspension applies.

12. What are the requirements for submitting COVID-19 related claims?

Please use the scenarios below and on the following page to find the most specific and accurate diagnosis code. Using these codes will support claims processing associated with COVID-19 screening, diagnosis, testing and treatment services.

COVID-19 Code Set effective 3/5/2020

COVID-19 Screening: Any Dx below on any position of the claim with any Place of Service

Table 1 - Screening for COVID-19	
Any Position on the Claim	
B34.2	Coronavirus Infection, Unspecified
B97.29	Other coronavirus as the cause of diseases classified elsewhere
J12.81	Pneumonia due to SARS-associated coronavirus
J12.89	Other viral pneumonia
J20.8	Acute bronchitis due to other specified organisms
J22	Unspecified acute lower respiratory infection
J40	Bronchitis, not specified as acute or chronic
J80	Acute respiratory distress syndrome
J98.8	Other specified respiratory disorders
R05	Cough
R06.02	Shortness of breath
R06.03	Acute respiratory distress
R50.9	Fever
Z03.818	Encounter for observation for suspected exposure to other biological agents ruled out
Z11.59	Encounter for screening for other viral diseases
Z20.828	Contact with and (suspected) exposure to other viral communicable diseases
Z86.19	Personal history of other infectious and parasitic diseases

COVID-19 Laboratory Screening:
Any code listed below with no diagnosis code requirement

Laboratory Coding	
87635	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique **(Effective 3/13/2020)**
U0001	Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel SARS-CoV-2 **(Effective 4/1/2020)** ***for dates of service on or after 2/4/2020**
U0002	Novel Coronavirus Test Panel SARS-CoV-2/2019-nCoV **(Effective 4/1/2020)** ***for dates of service on or after 2/4/2020**
G2023	Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source. **(Effective 3/1/2020)**
G2024	Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a SNF or by a laboratory on behalf of a HHA, any specimen source. **(Effective 3/1/2020)**
86328	Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single step method (eg, reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) **(Effective 4/10/2020)**
86769	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) multiple-step method **(Effective 4/10/2020)**

COVID-19 Treatment:
Any position on the claim, any POS

Diagnosis for confirmed COVID-19 infection	
REQUIRED - Any Position on the Claim	
U07.1	Covid-19 Acute Respiratory Distress **(Effective 4/1/2020)**

Modifiers (Optional) *Medicare required	
CR	Catastrophe/Disaster

Facility Condition Code (Optional) *Medicare required	
DR	Disaster related

Medicare Telehealth Frequently Asked Questions (FAQs)
March 17, 2020

1. **Q: How will recently enacted legislation allow CMS to utilize Medicare telehealth to address the declared Coronavirus (COVID-19) public health emergency?**

   A: The Coronavirus Preparedness and Response Supplemental Appropriations Act, as signed into law by the President on March 6, 2020, includes a provision allowing the Secretary of the Department of Health and Human Services 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 to allow beneficiaries in all areas of the country to receive telehealth services, including at their home.

2. **Q: What does this mean? What payment requirements for Medicare telehealth services are affected by the waiver?**

   A: Under the waiver, limitations on where Medicare patients are eligible for telehealth will be removed during the emergency. In particular, patients outside of rural areas, and patients in their homes will be eligible for telehealth services, effective for services starting March 6, 2020.

3. **Q: Why wasn't this done before?**

   A: Current telehealth law only allows Medicare to pay practitioners for services like routine visits furnished through telehealth under certain circumstances. For example, the beneficiary receiving those services must generally be located in a rural area and in a medical facility. Where the beneficiary receives those services is known as the "eligible originating site." The beneficiary's home is generally not an eligible originating site, but under the new 1135 waiver, this will be waived during the emergency. This will now allow telehealth services to be provided in all settings – including at a patient's home.

4. **Q: What services can be provided by telehealth under the new emergency declaration?**

   A: CMS maintains a list of services that are normally furnished in-person that may be furnished via Medicare telehealth. This list is available here: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes. These services are described by HCPCS codes and paid under the Physician Fee Schedule. Under the emergency declaration and waivers, these services may be provided to patients by professionals regardless of patient location.

   Medicare pays separately for other professional services that are commonly furnished remotely using telecommunications technology without restrictions that apply to Medicare Telehealth. These services, including physician interpretation of diagnostic tests, care management services and virtual check-ins, are normally furnished through communication technology.

5. **Q: Would physicians and other Qualified Providers be able to furnish Medicare telehealth services to beneficiaries in their homes?**

   A: Yes. The waiver temporarily eliminates the requirement that the originating site must be a physician's office or other authorized healthcare facility and allows Medicare to pay for telehealth services when beneficiaries are in their homes or any setting of care.

6. **Q: Who are the Qualified Providers who are permitted to furnish these telehealth services under the new law?**

   A: Qualified providers who are permitted to furnish Medicare telehealth services during the Public Health Emergency include physicians and certain non-physician practitioners such as nurse practitioners, physician assistants and certified nurse midwives. Other practitioners, such as certified nurse anesthetists, licensed clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals may also furnish services within their scope of practice and consistent with Medicare benefit rules that apply to all services. This is not changed by the waiver.

7. **Q: Will CMS enforce an established relationship requirement?**

   A: No. It is imperative during this public health emergency that patients avoid travel, when possible, to physicians' offices, clinics, hospitals, or other health care facilities where they could risk their own or others' exposure to further illness. Accordingly, the Department of Health and Human Services (HHS) is announcing a policy of enforcement discretion for Medicare telehealth services furnished pursuant to the waiver under section 1135(b)(8) of the Act. To the extent the waiver (section 1135(g)(3)) requires that the patient have a prior established relationship with a particular practitioner, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.

8. **Q: Is any specialized equipment needed to furnish Medicare telehealth services under the new law?**

   A: Currently, CMS allows for use of telecommunications technology that have audio and video capabilities that are used for two-way, real-time interactive communication. For example, to the extent that many mobile computing devices have audio and video capabilities that may be used for two-way, real-time interactive communication they qualify as acceptable technology.

   The new waiver in Section 1135(b) of the Social Security Act explicitly allows the Secretary to authorize use of telephones that have audio and video capabilities for the furnishing of Medicare telehealth services during the COVID-19 PHE. In addition, effective immediately, the HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency. For more information: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/index.html

9. **Q: How does a qualified provider bill for telehealth services?**

   A: Medicare telehealth services are generally billed as if the service had been furnished in-person. For Medicare telehealth services, the claim should reflect the designated Place of Service (POS) code 02-Telehealth, to indicate the billed service was furnished as a professional telehealth service from a distant site.

10. **Q: How much does Medicare pay for telehealth services?**

    A: Medicare pays the same amount for telehealth services as it would if the service were furnished in person. For services that have different rates in the office versus the facility (the site of service payment differential), Medicare uses the facility payment rate when services are furnished via telehealth.

11. **Q: Are there beneficiary out of pocket costs for telehealth services?**

    A: The use of telehealth does not change the out of pocket costs for beneficiaries with Original Medicare. Beneficiaries are generally liable for their deductible and coinsurance; however, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

12. **Q: How long does the telehealth waiver last?**

    A: The telehealth waiver will be effective until the PHE declared by the Secretary of HHS on January 31, 2020 ends.

13. **Q: Can hospitals, nursing homes, home health agencies or other healthcare facilities bill for telehealth services?**

    A: Billing for Medicare telehealth services is limited to professionals. (Like other professional services, Critical Access Hospitals can report their telehealth services under CAH Method II). If a beneficiary is in a health care facility (even if the facility is not in a rural area or not in a health professional shortage area) and receives a service via telehealth, the health care facility would only be eligible to bill for the originating site facility fee, which is reported under HCPCS code Q3014. But the professional services can be paid for.

14. **Q: Can qualified providers let their patients know that Medicare covers telehealth?**

    A: Yes. Qualified providers should inform their patients that services are available via telehealth.

15. **Q: Should on-site visits conducted via video or through a window in the clinic suite be reported as telehealth services?**

    A: Services should only be reported as telehealth services when the individual physician or professional providing the telehealth service is not at the same location as the beneficiary.

16. **Q: How is this different from virtual check-ins and e-visits?**

    A: A virtual check-in pays professionals for brief (5-10 min) communications that mitigate the need for an in-person visit, whereas a visit furnished via Medicare telehealth is treated the same as an in-person visit, and can be billed using the code for that service, using place of service 02 to indicate the service was performed via telehealth. An e-visit is when a beneficiary communicates with their doctors through online patient portals.

17. **Q: Are the telehealth services only limited to services related to patients with COVID-19?**

    A: No. The statutory provision broadens telehealth flexibility without regard to the diagnosis of the patient. This is a critical point given the importance of social distancing and other strategies recommended to reduce the risk of COVID-19 transmission, since it will prevent vulnerable beneficiaries from unnecessarily entering a health care facility when their needs can be met remotely. For example, a beneficiary could use this to visit with their doctor before receiving another prescription refill. However, Medicare telehealth services, like all Medicare services, must be reasonable and necessary under section 1862(a) of the Act.

18. **Q: Will CMS require specific modifiers to be applied to the existing codes?**

    A: CMS is not requiring additional or different modifiers associated with telehealth services furnished under these waivers. However, consistent with current rules, there are three scenarios where modifiers are required on Medicare telehealth claims. In cases when a telehealth service is furnished via asynchronous (store and forward) technology as part of a federal telemedicine demonstration project in Alaska and Hawaii, the GQ modifier is required. When a telehealth service is billed under CAH Method II, the GT modifier is required. Finally, when telehealth service is furnished for purposes of diagnosis and treatment of an acute stroke, the G0 modifier is required.

19. **Q: What flexibilities are available in the Medicaid program to provide care via telehealth for individuals who are quarantined or self-isolated to limit risk of exposure?**

    A: 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.

    More information is available:
    https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html

###