

## VOLUNTARY JOINT BILLING GUIDANCE

### Care Provided in Outpatient Sites During the COVID-19 Pandemic

*Updated: August 27, 2020*

America's Health Insurance Plans (AHIP) and the Healthcare Financial Management Association (HFMA) stand together with America's frontline healthcare heroes and leaders to fight against the novel coronavirus (COVID-19). The pandemic is an unprecedented crisis overwhelming the healthcare system. To increase capacity, health systems have been resourcefully utilizing alternate care sites and modalities to meet demand. This may require the use of certain healthcare sites for a different level of care than is customary (e.g., ambulatory surgical centers, the patient's home, via telehealth) or the use of nontraditional temporary sites (e.g., parks, parking lots, convention centers).

To support and accommodate the expansion in care due to COVID-19, health insurance providers are affording flexibilities to their clinical providers to bill for these services furnished in alternate sites of care. However, the existing billing and coding infrastructure was not designed for this. Various international, federal and private entities have had to issue new diagnosis and billing codes as well as guidance on their use by stakeholders. Clinicians and health systems are struggling to keep up with seemingly constant changes in how they are expected to bill amid the turmoil, while health insurance plans are scrambling to make necessary changes in their billing adjudication systems.

HFMA and AHIP partnered to provide clear, useful voluntary guidance for providers to code, bill and seek payment for services rendered in temporary, alternate healthcare sites that may be used during the COVID-19 public health emergency (PHE). The voluntary guidance is intended to reduce the burdens faced by providers when billing in these unprecedented circumstances, increase the accuracy and timeliness of payment, ensure appropriate patient cost-sharing waivers are implemented and improve population health surveillance. This guidance is not binding, but rather available for voluntary use by providers and health insurance providers. However, the guidance does reflect some legal requirements of the Medicare program as well as laws such as the Health Insurance Portability and Accountability Act and the Families First Coronavirus Response Act. We have attempted to note when we are referencing a legal requirement but are not offering legal or compliance advice; providers and health insurance providers should not rely on anything in this guidance as such. Also, nothing in this voluntary guidance is intended to address payment rates, which are the subject of arrangements between individual health insurance providers and individual providers. The intention of this voluntary guidance, developed collaboratively by hospitals and health insurance providers, is to reduce unnecessary administrative burden-related coding and billing complications that have arisen in this complex, and constantly evolving, situation.

This set of billing scenarios focuses on outpatient services and is intended to be valid for the duration of the PHE. The organizations have also released inpatient hospital service [scenarios](#). Both will be updated as needed.

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### Outpatient Level of Care

Below we offer voluntary guidance on the diagnosis and billing codes to process outpatient claims associated with these alternate sites of care and common scenarios arising from treatment or testing related to COVID-19 during the PHE. In addition, we provide a list of outpatient care scenarios to which this voluntary billing convention guidance applies as well as notes to provide context on how entities may apply the codes and billing conventions. As a point of clarity, while these scenarios could include services to patients with COVID-19, it is not exclusively so. Patients who do not have COVID-19 but are served in alternate locations to increase capacity are also included.

**Type of Bill.** The type of bill used will depend on where the service was provided and what portion of the service is being billed.

- Professional Fee: Claims should be billed on a CMS 1500/837p with the appropriate place of service code.<sup>1</sup>
- Technical Component of Services Provided in a Freestanding Clinic: Claims should be billed on a CMS 1500 with the appropriate place or service code.<sup>2</sup>
- Technical Component of Services Provided in a Hospital Outpatient Department (HOPD): Claim should be billed on a 13x, 14x (Hospital) or 85x (Critical Access Hospital – CAH) type of bill on the UB04/837i electronic transaction.

**Condition Code.** In order to ensure appropriate flagging of COVID-19-related care, the National Uniform Billing committee (NUBC)<sup>3</sup> recommends that institutional claims for COVID-19 diagnosis or treatment should include the “DR” condition code,<sup>4</sup> which is used to identify claims that are or may be impacted by specific policies related to a national or regional disaster/emergency. NUBC instructs that this should be reported in form locators 18 - 28 of the claim for these scenarios to flag the claim for special handling during the PHE, whether or not the patient has or is suspected to have COVID-19.

### Modifiers:

- CR: In order to ensure appropriate flagging of COVID-19-related care, the CR modifier<sup>5</sup> is used in relation to outpatient items and services for both institutional and non-institutional billing. Non-institutional billing, i.e., claims submitted by “physicians and other suppliers,” are submitted either on a professional paper claim form CMS-1500 or in the electronic format (837p).<sup>6</sup>
- CS: 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 specific payment systems outlined in the April 7 message 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 to get 100% of the Medicare-approved amount. Additionally, they should NOT charge Medicare patients any co-insurance and/or deductible amounts for those services.<sup>7</sup> Other health plans may also use this modifier to indicate special handling for waiver of cost sharing based on Families First Coronavirus Response Act obligations.<sup>8</sup>

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**Diagnosis Codes.** To identify COVID-19 cases, follow the most up-to-date CDC diagnosis coding guidance.<sup>9</sup> A synopsis is provided in Table 1 below, but this does not include the full coding hierarchy.

**Table 1.** ICD-10 Diagnosis Codes Applicable to COVID-19

COVID-19 Status	Diagnosis Code <sup>10</sup>
<b>Confirmed</b>	For COVID-19 <b>confirmed</b> cases on or after April 1, 2020, code diagnosis <b>U07.1</b> (B97.29 prior to April 1)
<b>Suspected</b>	For COVID-19 <b>suspected, probable, possible or inconclusive</b> cases, assign code related to reason for encounter (i.e., fever) or <b>Z20.828</b> , contact with, and (suspected) exposure to other viral communicable diseases.
<b>Exposed</b>	But was ruled out after evaluation, code <b>Z03.818</b> , encounter for observation for suspected exposure to other biological agents <b>ruled out</b> .  And the exposure was an <b>actual exposure</b> to someone who is confirmed or suspected (not ruled out) to have COVID-19, and exposed individual either tests <b>negative</b> or the test results are <b>unknown</b> , assign code <b>Z20.828</b> , contact with and (suspected) exposure to other viral communicable diseases.
<b>Asymptomatic</b>	And were screened for COVID-19 with no known exposure to the virus, and the test results are either <b>unknown or negative</b> , assign code <b>Z11.59</b> , encounter for screening for other viral diseases.

### Applicable Outpatient Billing Scenarios

Table 2 contains a listing of the scenarios to which this voluntary billing guidance applies. Given the constantly changing environment, while extensive, Table 2 is likely not comprehensive. Note that unless a specific coding or CMS document is referenced, the guidance contained in Table 2 is a product of joint efforts by HFMA and AHIP to arrive at solutions that reduce administrative uncertainty and inefficiency in this crisis and are offered for voluntary use by providers and plans. Given that many of the scenarios are treated in the same manner, the governing document will only be referenced in the guidance's initial appearance.

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**Table 2.** Applicable Outpatient Billing Scenarios

*For testing and related services, health plans will determine which services should be covered without cost sharing based on the ICD-10 code and/or the presence of one of the testing CPT/HCPCS modifiers or condition codes, except where otherwise noted in this table.*

Scenario	Notes
<b>Section 1: Telehealth<sup>a,b</sup> Services Delivered in Specified Sites</b>	
Patient's Home – Evaluation & Management (Professional Fee)	<ul style="list-style-type: none"> <li>▪ Bill on 1500/837p.</li> <li>▪ See CMS guidance on E/M codes.<sup>11</sup></li> <li>▪ Use place-of-service (POS) code that the provider would typically bill had this visit been in person for Medicare (I.E. 11,22).</li> <li>▪ Apply the 95 modifier for Medicare claims.</li> <li>▪ Check with other insurers to determine if the 95 modifier should be used. While consistency with Medicare is recommended, POS 02 may be used as an alternative.</li> <li>▪ Use the CS modifier for COVID-19 tests and testing-related services (e.g., E/M code); however, some insurers will process claims without the modifier based on a claims algorithm and/or the presence of the CR Modifier.</li> </ul>
Emergency Department (ED) (Professional Fee, patient and provider at different locations)	<ul style="list-style-type: none"> <li>▪ Bill on 1500/837p.</li> <li>▪ Use ED telehealth codes: 99281 – 99285.</li> <li>▪ Use POS code 23.</li> <li>▪ Apply the 95 modifier for Medicare.</li> <li>▪ Check with other insurers to determine if the 95 modifier should be used. While consistency with Medicare is recommended, POS 02 may be used as an alternative.</li> <li>▪ Use the CS modifier for COVID-19 tests and testing-related services (e.g., E/M code); however, some insurers will process claims without the modifier based on a claims algorithm and/or the presence of the CR Modifier.</li> </ul>
Observation Stay (Professional Fee, patient and provider at different locations)	<ul style="list-style-type: none"> <li>▪ Bill on 1500/837p.</li> <li>▪ Use telehealth codes: 99218-99220, 99217.</li> <li>▪ Use POS code 22.</li> <li>▪ Apply the 95 modifier for Medicare.</li> <li>▪ Check with other insurers for coverage rules and to determine if the 95 modifier should be used. While consistency with Medicare is recommended, POS 02 may be used as an alternative.</li> <li>▪ Use the CS modifier for COVID-19 tests and testing-related services (e.g., E/M code); however, some insurers will process claims without the modifier based on a claims algorithm and/or the presence of the CR Modifier.</li> </ul>

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<sup>a</sup> This section only applies to visits that meet the face-to-face requirement. Includes video and voice.

<sup>b</sup> This section applies to the professional fee only.

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<b>Section 1</b> <i>(continued)</i>	
<p>Skilled Nursing Facility (SNF) or Nursing Facility (NF)</p> <p>(Professional Fee, patient and provider at different locations)</p>	<ul style="list-style-type: none"> <li>▪ Bill on 1500/837p.</li> <li>▪ See CMS guidance on E/M codes.</li> <li>▪ POS code 31 (SNF), 32 (NF).</li> <li>▪ Apply the 95 modifier for Medicare.</li> <li>▪ Check with other insurers to determine if the 95 modifier should be used. While consistency with Medicare is recommended, POS 02 may be used as an alternative.</li> <li>▪ Use the CS modifier for COVID-19 tests and testing-related services (e.g., E/M code); however, some insurers will process claims without the modifier based on a claims algorithm and/or the presence of the CR Modifier.</li> </ul>
<p>Via Telephone (Professional Fee)</p>	<ul style="list-style-type: none"> <li>▪ Bill on 1500/837p.</li> <li>▪ Use codes 98966-98968 or 99441-99443.</li> <li>▪ POS code 11, 19 or 22.</li> <li>▪ CR modifier not required for Medicare.</li> <li>▪ Can be billed for both new and established patients.<sup>12</sup></li> <li>▪ Consult with other insurers regarding coverage policy and CR modifier as requirements may vary.</li> <li>▪ Some states have specific Medicaid language detailing that this service is covered in the absence of video capabilities.</li> <li>▪ Use the CS modifier for COVID-19 tests and testing-related services (e.g., E/M code); however, some insurers will process claims without the modifier based on a claims algorithm and/or the presence of the CR Modifier.</li> </ul>
<p>Provide Ongoing Monitoring for Another Chronic Condition</p>	<ul style="list-style-type: none"> <li>▪ Bill on 1500/837p.</li> <li>▪ Use codes 99453 - 99454 or 99457.</li> <li>▪ POS code 11.</li> <li>▪ New and established patients e-visits.<sup>13</sup></li> <li>▪ No COVID-19 modifiers used.</li> </ul>

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<b>Section 2: Outpatient Service Locations for E/M (Non-telehealth)</b>	
HOPD (Including Off-Campus Provider-Based Settings)	<ul style="list-style-type: none"> <li>▪ Bill on 1500/837P and/or UB04/837i.</li> <li>▪ Bill with applicable E/M codes.</li> <li>▪ POS code 19/22 (1500).</li> <li>▪ When the patient and the provider are on the same campus/location, but not in the same room (e.g., care is provided virtually) follow the Medicare guidelines and bill the encounter as a face-to-face visit.</li> <li>▪ Include PN/PO modifier as appropriate, based on plan requirements.</li> <li>▪ Use the CS modifier for COVID-19 tests and testing-related services (e.g., E/M code); however, some insurers will process claims without the modifier based on a claims algorithm and/or the presence of the DR condition code (facility claim) or the CR Modifier (professional claim).</li> </ul>
Freestanding Clinic Owned by Hospital	<ul style="list-style-type: none"> <li>▪ Bill on 1500/837p.</li> <li>▪ Bill with standard E/M codes.</li> <li>▪ POS code 11.</li> <li>▪ When the patient and the provider are on the same campus/location, but not in the same room (e.g., care is provided virtually) follow the Medicare guidelines and bill the encounter as a face-to-face visit.</li> <li>▪ Use the CS modifier for COVID-19 tests and testing-related services (e.g., E/M code); however, some insurers will process claims without the modifier based on a claims algorithm and/or the presence of the DR condition code (facility claim) or the CR Modifier (professional claim).</li> </ul>
Ambulatory Surgical Centers (under arrangement as an HOPD)	<ul style="list-style-type: none"> <li>▪ Bill on 1500/837p and/or UB04/837i.</li> <li>▪ Bill with standard E/M codes.</li> <li>▪ POS code 22 (1500).</li> <li>▪ Use the CS modifier for COVID-19 tests and testing-related services (e.g., E/M code); however, some insurers will process claims without the modifier based on a claims algorithm and/or the presence of the DR condition code (facility claim) or the CR Modifier (professional claim).</li> </ul>
Field Hospital (ED Services) Staffed by an Established Hospital's Physicians/ Clinicians	<ul style="list-style-type: none"> <li>▪ Bill on 1500/837p and/or UB04/837i.</li> <li>▪ Bill with standard ED E/M codes.</li> <li>▪ POS Code 23 (1500).</li> <li>▪ Use the CS modifier for COVID-19 tests and testing-related services (e.g., E/M code); however, some insurers will process claims without the modifier based on a claims algorithm and/or the presence of the DR condition code (facility claim) or the CR Modifier (professional claim).</li> </ul>

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Waiver of Patient Liability	
<p>Drive Through/Walk-Up Testing Site – COVID-19</p>	<ul style="list-style-type: none"> <li>▪ Bill on 1500/837p and/or UB04/837i.</li> <li>▪ Specimen collection codes<sup>c</sup> 99211 (1500)/C9803 (837p).<sup>14</sup></li> <li>▪ No POS on the 837i/UB04.</li> <li>▪ Consult POS guidance for professional claims depending on the structure of the testing site.</li> <li>▪ Bill using CR modifier/DR condition code depending on the claim form and payer requirements.</li> <li>▪ Use the CS modifier for COVID-19 tests and testing-related services (e.g., E/M code); however, some insurers will process claims without the modifier based on a claims algorithm and/or the presence of the DR condition code (facility claim) or the CR modifier (professional claim).</li> <li>▪ Cost sharing for the visit or specimen collection, including testing, is waived.</li> </ul>
<p>Drive Through/Walk-Up Testing Site – Non-COVID-19</p> <p>Anti-coagulation drive-through clinic, followed up with a telehealth visit (in instances where these services are billable)</p>	<ul style="list-style-type: none"> <li>▪ Bill on 1500/837p and/or UB04/837i.</li> <li>▪ Bill using CR/DR depending on the claim form and payer requirements.</li> </ul>

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<sup>c</sup> if the specimen collection is not otherwise described/included in another E/M service CPT/HCPCS code provided during the visit.

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<b>Waiver of Patient Liability</b> <i>(continued)</i>	
<p>Patient is tested in the ED, a provider office, urgent care center or other ambulatory location based on symptoms or direct exposure to an individual who has tested positive for COVID-19. The patient returns home after receiving evaluation and testing.</p>	<ul style="list-style-type: none"> <li>▪ Bill on 1500/837p and/orUB04/837i.</li> <li>▪ Use the CS modifier for COVID-19 tests and testing-related services (e.g., E/M code); however, some insurers will process claims without the modifier based on a claims algorithm and/or the presence of the DR condition code (facility claim) or the CR modifier (professional claim).</li> <li>▪ For commercial plans, cost sharing for the E/M code, testing, services that result in an order for a test (e.g., chest x-ray, panels for influenza A and B and respiratory syncytial virus), and any facility fee<sup>15</sup> is waived.</li> <li>▪ For Medicare FFS, cost sharing is waived for testing and related E&amp;M services based on HCPCS codes identified by CMS.<sup>16</sup></li> <li>▪ Medicare Advantage plans are required to cover testing and the same related E&amp;M services as Medicare FFS.<sup>17</sup></li> <li>▪ Medicaid and the Children's Health Insurance Program (CHIP) require additional clarity to determine the "related services" subject to the cost sharing waiver.<sup>18</sup></li> </ul>
<p>Patient is tested in the ED and is subsequently admitted to an inpatient unit. The test and ED visit would be rolled into the inpatient stay.</p>	<p>Cost sharing for testing is not waived<sup>19</sup> as testing is incorporated into the cost of treatment.</p>
<p>Patient is tested in the ED and subsequently admitted to observation and discharged from observation</p>	<ul style="list-style-type: none"> <li>▪ Medicare FFS and Medicare Advantage include observation stays in the testing cost-sharing waiver.<sup>20</sup></li> <li>▪ Commercial plans, Medicaid and CHIP require more clarity.<sup>21</sup></li> </ul>
<p>Patient is tested as a result of a direct inpatient admission.</p>	<p>Cost sharing for testing is not waived<sup>22</sup> as testing is incorporated into the cost of treatment.</p>

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### Endnotes

- 1 CMS. ["Place of Service Code Set: Place of Service Codes for Professional Claims Database."](#) Accessed May 2020.
- 2 Ibid
- 3 NUBC. ["Claims for COVID 19 Treatment."](#)
- 4 ["Medicare Fee-for-Service \(FFS\) Response to the Public Health Emergency on the Coronavirus \(COVID-19\)"](#)
- 5 Ibid
- 6 CMS. *MLN Matters*. ["Medicare Fee-for-Service Response to the Public Health Emergency on the Coronavirus \(COVID-19\)."](#)
- 7 CMS. *MLN Matters*, ["COVID-19: Infection Control, Maximizing Workforce, Updated Q&A, CS Modifier for Cost-Sharing, Payment Adjustment Suspended."](#)
- 8 ["Families First Coronavirus Response Act."](#)
- 9 Centers for Disease Control and Prevention. ["ICD-10-CM Official Coding and Reporting Guidelines April 1, 2020 through September 30, 2020."](#)
- 10 Current as of April 28, 2020
- 11 CMS. ["Covered Telehealth Services for PHE for the COVID-19 Pandemic, effective March 1, 2020 – Updated 04/30/20."](#) Accessed May 2020.
- 12 CMS. ["Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency."](#) (Interim Final Rule with Comment Period)
- 13 CMS. ["COVID-19 Frequently Asked Questions on Medicare Fee-for-Service Billing."](#)
- 14 CMS. ["Medicare and Medicaid Programs, Basic Health Program, and Exchanges: Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program."](#) (Interim Final Rule with Comment Period)
- 15 Department of Labor. [FAQS About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 43](#)
- 16 CMS *MLN Matters*. ["COVID-19: Waive Cost-Sharing for These HCPCS Codes"](#)
- 17 ["Families First Coronavirus Response Act, Section 6003\(1\)\(B\)"](#)
- 18 ["Families First Coronavirus Response Act \(FFCRA\), Public Law No. 116-127 Coronavirus Aid, Relief, and Economic Security \(CARES\) Act, Public Law No. 116-136 Frequently Asked Questions \(FAQs\)"](#)
- 19 CMS. *MLN Matters*. ["Medicare Fee-for-Service Response to the Public Health Emergency on the Coronavirus \(COVID-19\)."](#)
- 20 Ibid
- 21 CMS. ["FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 42."](#)
- 22 CMS. *MLN Matters*. ["Medicare Fee-for-Service Response to the Public Health Emergency on the Coronavirus \(COVID-19\)."](#)