COVID-19
AND
MEDICARE
REMOTE SERVICES
REVISED APRIL 20, 2020

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AOA Coding and Reimbursement
April 2020
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Outline

CMS Changes under 1135 Waiver

• Discussion of 1135 Waiver Changes
• CMS Changes for Non-Face to Face Services Overview
• CPT Codes for Evaluations – Non-Face to Face
• CMS coverage for Telemedicine
• CMS coverage for Types of Remote Visits
• Discussion of other information regarding payments
Legislative Response
COVID-19 Public Health Emergency

March 6: Legislation gives DHHS **authority** to remove the Telehealth Services use restrictions

March 17: CMS relaxed Telehealth Rules for Medicare under **1135 Waiver** for duration of COVID-19 Health Emergency retroactive to March 6, 2020

March 30, 2020: CMS expanded telehealth use
- Changed POS to use -11
- Changed Modifier to use to -95 for Telemedicine
Retroactive to March 6, 2020
AOA Efforts Related to COVID-19 and Impacts on Optometry Practices

• AOA ensured doctors of optometry were fully recognized as qualified physicians under legislation signed into law on March 6 which increased funding for national response to the COVID 19 public health emergency

• Multiple Reports of Denials due to provider types

• LET AOA KNOW ASAP if you receive denials
AOA Efforts Related to COVID-19 and Impacts on Optometry Practices

Legislation allows for Department of Health and Human Services (DHHS) to temporarily waive certain Medicare restrictions and requirements regarding telehealth services during the coronavirus public health emergency (1135 Waiver)

**Initial policy rules ISSUED March 17, 2020**

**Altered March 30, 2020**

**All retroactive to March 6, 2020**

AOA’s Health Policy Institute continues to provide guidance to doctors of optometry on COVID-19

AOA Efforts Related to COVID-19 and Impacts on Optometry Practices

Using 1135 Waiver CMS relaxed rules

- Medicare can pay for office, hospital, and certain other visits furnished via telehealth across the country and including in patient’s places of residence starting March 6, 2020.

- HHS Office of Inspector General (OIG) providing flexibility for healthcare providers to reduce/waive deductibles/copays for telehealth visits paid by federal healthcare programs (provider choice)
Types of Non-Face to Face Visit Codes

Non-Face to Face Services

- Telemedicine Services
- Virtual Check In
- E-visits
- Telephone Services
Difference between Telehealth vs Telemedicine

Modifier 95:
Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System

Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional.

Synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.

Telehealth = broader scope of remote healthcare services than telemedicine and includes all Non-face-to-face services
Telemedicine Visits: Visit with provider using real-time, interactive audiovisual telecommunication systems between a provider and a patient

Virtual Check-Ins: Brief (5-10 minutes) check in with provider via telephone or other telecommunications device to decide if office visit/other service necessary OR A remote evaluation of recorded video and/or images submitted by established patient

E-Visits: Communication between patient and provider via online patient portal

Telephone Services: Non-face-to-face E&M services via telephone audio only

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
Telemedicine Normal Rules
And Changes Subsequent to CMS Action
What Changed
Medicare Telemedicine Service Defined

Includes:

1. Office visits
2. Psychotherapy
3. Consultations
4. Certain other medical or health services

- Providers not at patient location
- Only with live, interactive 2-way telecommunications system (e.g. real-time audio and video)
Types of Technology Used for Telemedicine
Under 1135 Waiver

- CMS will allow use of phones with video ability for telemedicine “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.”

- HHS Office for Civil Rights (OCR) – HIPAA enforcement discretion and waiving penalties for good faith care via everyday communications technologies, such as FaceTime or Skype, during COVID-19 pandemic

- BUT HHS, OIG, and DOJ continue to actively monitor for healthcare fraud and abuse, including potential Medicare coronavirus scams
Medicare Telemedicine Service Defined

March 2020 action allows for telehealth services to be provided by doctors of optometry using “everyday communications technologies” such as FaceTime or Skype or Zoom.

Some types of audio/video communications are NOT allowed. Any technology used must be PRIVATE and not “forward facing.” Technologies like TikTok, Facebook Live are NOT ALLOWED.

https://www.hhs.gov/hipaa/for-professionals/special-topics/hipaa-covid19/index.html
Medicare Telemedicine Service Defined

**Normally** - Originating site=location of patient

Must be in county outside Metropolitan Statistical Area (MSA) or rural Health Professional Shortage Area (HPSA) in rural census tract (Medicare Telehealth Payment Eligibility Analyzer)

Distant Site=location of provider

March 2020 action allows for telemedicine services to be provided outside of previously designated areas by doctors of optometry
Medicare Telemedicine Service Defined

NORMALLY COVERED ONLY IF patient is one of following places:
1. Doctor's office
2. Hospital
3. Critical access hospital (CAH)
4. Rural health clinic
5. Federally qualified health facility
6. Hospital-based dialysis facility
7. Skilled nursing facility
8. Community mental health center
9. Patient home if End-Stage Renal Disease (ESRD)-home dialysis
10. Mobile Stroke Units

March 2020 action allows telemedicine services to be provided by doctors of optometry when patient at home or elsewhere
# Medicare Telemedicine Service Billing

<table>
<thead>
<tr>
<th>Code</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
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<tr>
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<tr>
<td>99214</td>
<td></td>
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<tr>
<td>99215</td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:**

92002, 92012, 92004, 92014 ARE **NOT INCLUDED**

Under 1135 Waiver ONLY - **Must file Medicare with -95 modifier**

**Place of Service (POS) = 11 office**

**NEW POS:**
Where service typically provided
Medicare Telemedicine Service Defined

Now approved separate E&M codes for different settings of care, such as:

- office/outpatient codes
- nursing facility codes
- emergency department

CMS expectation:
Physicians use E&M code that best describes nature of care provided regardless of physical location or status of patient

If Provider NOT in typical location:
- Still use Typical POS (11-office)
- Put actual location address in Block 32 for CMS 1500 form
Medicare Telemedicine Service Defined

CMS Exceptions:

1135 Waiver COVID-19 Public Health Emergency

Office/outpatient E&M level selection for telemedicine services can be based on:

- MDM
- Time, with time defined as all of time associated with the E&M on day of encounter

Remove requirements for documentation of history and/or physical exam in record
Medicare Telemedicine Service Defined

- CMS COVID-19 Telemedicine new rules:
  - Similar to policy that will apply to all office/outpatient E&M codes in 2021

- CMS expects providers will document E&M visits as necessary to ensure quality and continuity of care

For COVID-19 Changes in 2020

- CMS maintaining current definition of MDM under 2020 rules
- CMS maintaining typical times associated with office/outpatient E&M codes
- CMS expects typical times under 2020 rules should be met for purposes of level selection
Use of Medical Decision Making or Time for Telemedicine E&M Code Level Selection

From CMS Final Rule March 30, 2020

“It remains our expectation that practitioners will document E&M visits as necessary to ensure quality and continuity of care. To reduce the potential for confusion, we are maintaining the current definition of MDM. We note that currently there are typical times associated with the office/outpatient E&Ms, and we are finalizing those times as what should be met for purposes of level selection.”
Medical Decision Making-2020

1. Number of diagnoses possible
2. Risk of morbidity and mortality
3. Diagnostic procedures ordered
4. Management options
Medical decision making

• Other factors to secondarily consider
  – Counseling
  – Coordination of care
  – Nature of presenting problem
  – Time **

**Typically time only used when primarily counseling and care coordination BUT under COVID-19 1135 Waiver can choose to use time over Medical Decision Making if desired

And

**MUST** document carefully when using time

Start time End Time and other time spent by physician
Straight Forward Medical Decision Making

(99201, 99202, 99212)
Minimum number diagnoses
Minimal management options
Minimal risk

Presenting problem(s): One self-limiting or minor problem
Diagnostic procedures: Simple testing to order
Management options: Simple comfort measures

CPT Example - 99201 - Initial office visit for a 10-year-old girl for determination of visual acuity as part of a summer camp physical (does not include determination of refractive error -92015)
Low Complexity Medical Decision Making

(99203, 99213)

Limited number of diagnoses
Limited management options
Low risk

Presenting problem(s): 2+ self-limiting or minor problems
One stable chronic
Acute, uncomplicated illness

Diagnostic procedures: Slightly more complicated testing
Management options: OTC meds or PT

CPT Example 99203 - Initial office visit for a 55-year-old female with chronic blepharitis. There is a history of use of many medications

CPT Example 99213 - Office visit for a 65-year-old female, established patient, with primary glaucoma for interval determination of intraocular pressure and possible adjustment of medication
Moderate Complexity Medical Decision Making

(99204, 99214)

Multiple diagnoses
Moderate management options
Moderate risk

Presenting problem(s): 1+ chronic w exacerbation/2+ stable chronic
Undiagnosed new problem
Acute with systemic symptoms
Acute complicated injury

Diagnostic procedures: More complicated options with higher risk

Management options: Rx meds or minor surgery

CPT Example 99214 - Office visit for a 68-year-old male, established patient, with the sudden onset of multiple flashes and floaters in the right eye due to a posterior vitreous detachment
High Complexity Medical Decision Making

(99205, 99215)

- Extensive number diagnoses
- Extensive management options
- High risk

Presenting problem(s):
- 1+chronic/severe exacerbation
- Acute/chronic illness with risk
- Abrupt neurologic status change

Diagnostic procedure: Extremely complicated testing
Management options: Major surgery
- IV medications
- DNR decision

**CPT Example 99205** - Initial office visit for a 70-year-old diabetic patient with progressive visual field loss, advanced optic disc cupping and neovascularization of retina
Medical Decision Making

Document

1. Findings
2. Visualizations
3. Plans
4. Test results
5. Consultations
6. Old record requests

Still need to document EVERYTHING!!
## COVID-19 ONLY Telemedicine Medical Decision Making

<table>
<thead>
<tr>
<th>CODE</th>
<th>HISTORY</th>
<th>EXAMINATION</th>
<th>DECISION</th>
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<td>Problem Focused</td>
<td>Straight Forward</td>
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<td>99211</td>
<td>Staff only</td>
<td>NA</td>
<td>NS</td>
</tr>
<tr>
<td></td>
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<td>NA</td>
<td>Per CMS</td>
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<td>Low</td>
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<tr>
<td>99215</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High</td>
</tr>
</tbody>
</table>
TIME and 2020 E&M Codes

Typical times associated with office/outpatient E&Ms are available at

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F

CY 2020 PFS Final Rule Physician Time (ZIP)

CY 2020 PFS Final Rule List of Telehealth Services (ZIP)

CMS-1744-IFC 137 policy only applies to office/outpatient visits furnished via Medicare telemedicine, and only during COVID-19 Public Health Emergency
# Telemedicine E&M Typical Times

*minutes*

<table>
<thead>
<tr>
<th>New Patient</th>
<th>CPT Typical Time</th>
<th>CMS Typical Time$^4$</th>
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</thead>
<tbody>
<tr>
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<td>17 min</td>
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</tr>
<tr>
<td>99205</td>
<td>60 min</td>
<td>67 min</td>
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</table>

<table>
<thead>
<tr>
<th>Established Patient</th>
<th>CPT Typical Time</th>
<th>CMS Typical Time$^4$</th>
</tr>
</thead>
<tbody>
<tr>
<td>99212</td>
<td>10 min</td>
<td>16 min</td>
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<tr>
<td>99215</td>
<td>40 min</td>
<td>55 min</td>
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</tbody>
</table>
Medicare Telemedicine Service Billing

Normally Telemedicine uses POS 02
Normally does not use modifiers
Normally pays at Facility rate
Normally patient has to be in specified place

BUT March 30, 2020
CMS changed rules

Under 1135 Waiver:
1. Add services available to be billed under Telemedicine
2. Use POS of 11 - office (typical POS where service provided)
3. Use -95 Modifier to indicate Telemedicine Service
4. Will pay at Non-facility rate
5. Patient can be at most any remote location
Medicare Telemedicine Service Billing

Modifier -95:
Synchronous Telemedicine Service Rendered via a Real-Time Audio/Video

CPT ® Appendix P:
Lists codes available for synchronous telemedicine services
CMS added 80+ more codes to allowed Telemedicine services
(home nursing facility rest and others)
List posted on AOA Coding Page
Telemedicine Claims Filed Prior to Rules Change

IF filed and paid for telemedicine claim prior to rules change using POS -02, you were paid at Facility Rate of reimbursement

Can file amended claim using POS 11 and Modifier -95

CMS SHOULD reprocess that claim using Non-facility Rate of reimbursement
Medicare Virtual Check In Services

• Medicare pays “virtual check-ins” for patients to connect with doctor in lieu of office visit

• NEW or Established patients only

• POS =11 (list actual address if different Block 32)

• Not related to medical visit in previous 7 days and does not lead to medical visit in next 24 hours

• Patient must verbally consent to services and verbal consent must be documented before service – At least annually

• Medicare coinsurance and deductible ($198) apply to these

-95 modifier ONLY applies to Telemedicine and not other non-face-to-face services
Medicare Virtual Check In Services

• Can bill for these virtual check-in services furnished through several communication technology modalities
  – G2012 – Telephone
  – G2010 - Captured video or image
Medicare Virtual Check In Services

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

National average reimbursement ~ $15

* Can be new patients under COVID-19 1135 Waiver
Medicare Virtual Check In Services

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.

- National average reimbursement ~ $12

* Can be new patients under COVID-19 1135 Waiver
Virtual Check In Coding

Question:
Can codes G2010 and G2012 be billed on the same day, by the same practitioner, for the same patient?

Answer:
As long as all requirements for billing both codes are met, and time and effort are not being counted twice, HCPCS codes G2010 and G2012 may be billed by the same practitioner, for the same patient, on the same day.
Medicare On-Line Digital Evaluations

- Medicare pays for patients to communicate with doctors without an office visit using on-line patient portals.
- **New or** Established patients
- Must be patient-initiated...but...
- Providers may educate beneficiaries on availability of services prior to patient initiation
- **New or established patients under 1135 Waiver**

-95 modifier ONLY applies to Telemedicine and not other non-face-to-care services
Medicare On-Line Digital Evaluations

• Communication may occur over 7-day period

• Not related to medical visit in previous 7 days and does not lead to medical visit in next 24 hours

• Bill using 99421-99423

• Medicare coinsurance and deductible ($198) apply (Note providers can waive during crisis only)

Normally required to store communication and ensure HIPAA compliance for ALL Patient Communications but not enforced during emergency
Medicare On-Line Digital Evaluations

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 (National Average reimbursement ~ $15.52)

99422
; 11–20 minutes (National Average reimbursement ~ $31.04)

99423
; 21 or more minutes (National Average reimbursement ~ $50.16)

* Can be new patients under COVID-10 1135 Waiver
Telephone Services

- Non-face-to-face evaluation and management (E&M) services provided using telephone (no video available)
- Used to report episodes of patient care initiated by New or established patient or guardian

-95 modifier ONLY applies to Telemedicine and not other non-face-to-face-care services
Telephone Services

Do not report IF:

1. Call results in decision to see the patient within 24 hours or next available urgent visit appointment (considered part of preservice work for visit)
2. Call refers to E&M service billed by provider within previous seven days whether requested by provider or not
3. Call is within postoperative period of completed procedure (part of post operative service)
4. Reported 99441-99443 by same provider for same problem in previous seven days
## Telephone Services

**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 (National average reimbursement ~ $14.44)

**99442** 11-20 minutes of medical discussion
(National average reimbursement ~ $28.15)

**99443** 21-30 minutes of medical discussion
(National average reimbursement ~ $41.14)

(Do not report 99441-99443 when using 99339-99340, 99374-99380 for the same call[s])
(Do not report 99441-99443 for home and outpatient INR monitoring when reporting 93792, 93793)
(Do not report 99441-99443 during the same month with 99487-99489)
(Do not report 99441-99443 when performed during the service time of codes 99495 or 99496)

* Can be new patients under COVID-10 1135 Waiver
**CS Modifier:**
COVID-19 Related Cost-Sharing Waiver

**CS modifier for COVID-19 related services only**

Must have COVID-19 ICD-10 diagnosis code for service

Services furnished on March 18, 2020 to end of Public Health Emergency

Use **CS modifier** on applicable claim lines to identify service subject to the cost-sharing waiver for COVID-19 testing-related services

Medicare will reimburse 100% of Medicare-approved amount

Providers should NOT charge Medicare patients any co-insurance and/or deductible amounts for those services
SARS-CoV-2 (COVID-19) ICD-10-CM Codes

**U07.1: Confirmed diagnosis of SARS-CoV-2 COVID-19**

SARS-CoV-2 With Complications: Use U07.1 first and then any complications
For example: Sars-CoV-2 and pneumonia

**U07.1**: Confirmed SAR-CoV-2 and **J12.89**: Other viral pneumonia

**Symptomatic "suspected/probable/inconclusive COVID-19**

Assign a code(s) explaining the reason for encounter like: **R05** Cough, **R06.02** Shortness of breath, **R50.9** Fever, unspecified

**OR**

**Z20.828**: Contact with and (suspected) exposure to other viral communicable diseases

**Exposure to SARS-CoV-2**: Exposure Only But Asymptomatic

**Z03.818**: Encounter for observation for suspected exposure to other biological agents ruled out

**Screening for COVID-19**

Asymptomatic /known exposure to the virus unknown test results code **Z11.59**: Encounter for screening for other viral diseases

Modifier Use Summary

- **95 Modifier** for **telemedicine services ONLY**

- **CS Modifier** only if services provided related to COVID-19 diagnosis

- **CR Modifier** is **NOT required** during this Public Health Emergency

- **GQ Modifier** if Alaska/ Hawaii using asynchronous telemedicine

- **GO Modifier** if telemedicine diagnosis is related to Acute Stroke diagnosis

Do not need modifiers for other Non-face-to-face services that not directly COVID-19 related
Vision Rehabilitation/Therapy Codes Via Telemedicine

Typical codes for Vision Rehabilitation/Therapy have not been approved for reporting via telemedicine. Medicaid and private payer policies may vary.

However, Vision Rehabilitation/Therapy could be provided by Telemedicine E&M codes or by using virtual check ins as long as you meet definition for the code 92065 and 97530 specifically are not covered under CMS guidelines for telemedicine.
Private Insurer Telehealth Summary

Many private insurers:

- **Some** apply same rules as CMS
- **Some** require use of modifiers GT, GQ, GO or 95
- **Some** use same CMS-designated Originating Sites for telemedicine - **Check with each private plan**
- **Some** use POS 02 – **Check with each private plan**
- **Some** follow any telehealth federal and state mandates
- **Some** allow telephone services - 99441-99443
- **Some** may allow online digital evaluation and management services - 99421-99423
- **Some** may allow G2010 and G2012

**ALWAYS** check with insurers directly to understand the rules
MIPS 2019 and COVID-19

COVID-19 Public Health Emergency only:
CMS is applying MIPS automatic extreme and uncontrollable circumstances policy to MIPS eligible clinicians for 2019 MIPS performance period for 2021 MIPS payment year

Because COVID-19 Public Health Emergency will likely impact provider ability to complete data submission for 2019 MIPS
Sequestration Adjustment Suspension

Section 3709 of CARES Act

Temporarily suspends 2% payment adjustment currently applied to all Medicare Fee-For-Service (FFS) claims due to sequestration

Suspension is effective for claims with dates of service from May 1, 2020 through December 31, 2020
HHS CARES Act Monies

April 10, 2020: Part of CARES Act:

Optometrists (and other physicians) who billed Medicare in 2019 began **receiving checks from DHHS to aid in supporting their practices** during the COVID-19 Public Health Emergency

This financial support is **not required to be paid back**

Funding from HHS came following correspondence from AOA from President Barbara L. Horn OD urging HHS to make direct payments immediately and to ensure that Doctors of Optometry would be recognized as fully eligible physicians under this program

HHS CARES Payment Possible Delay

HHS contacted UnitedHealth Group to deliver the CARES funds. You should receive payment within two weeks (from April 10, 2020) via Automated Clearing House (ACH).

The automatic payments will come via Optum Bank with “HHSPAYMENT” as the payment description.

If you have NOT received your payment you may not be signed up with UHG OptumBank so must open an ACH with them.

Call HHS at 1-877-620-6194 option 2
HHS will have you sign up (a one page document) and open an ACH.

While HHS cannot not tell you the amount, but will tell you if you are approved and that you should see the money in 10 business days.
HHS CARES Act Payment Information

Cares Act Monies Guidance

To be used for practice related expenses

Should sign on-line attestation

You received payment
You accept payment
You agree to abide by “rules”
Option of refusing payment

If do not attest, CMS assumes you agree and abide by rules

Main Rules:
Agree to waive cost sharing for ALL COVID-19 or Potential COVID-19 related visits
Monies to be used for practice related expenses

www.hhs.gov/provider-relief/index.html
Calculating CARES Medicare Relief Payment

Dividing 2019 Medicare FFS (not including Medicare Advantage) payments by $484,000,000,000 then multiply by $30,000,000,000

 Paid to the TIN

Example:

$100,000/$484,000,000,000 = 2.0661170

2.0661170 x $30,000,000,000 = $6198.35
CARES Act Medicare Monies

- AOA expect additional funding to be released to doctors in coming weeks
- AOA pushing HHS to do more to support doctors of optometry across the country, including those who do not care for traditional Medicare patients
- Doctors who have not yet received support from HHS should be able to check their status at: www.hhs.gov/providerrelief
Legislative Response
COVID-19 Public Health Emergency

AOA worked to:

• Ensure doctors of optometry were recognized as physicians and included as qualified providers to be able to continue to provide care via telehealth during this public health emergency.

IF you receive denial due to provider type for any Non face-to-face services, Let AOA Know Immediately
CMS Advanced/Accelerated Payment Program

- Must have billed Medicare for claims within 180 days immediately prior to application date
- Have to request a specific amount using an Accelerated or Advance Payment Request form provided on each MAC’s website
- Most can request up to 100% of Medicare payment amount for 90-day period
- Payment notice by Remittance Code: PLB AP code
CMS Advanced/Accelerated Payment Program

- Repayment begins **120 calendar days after payment is issued**
- MUST to be repaid within **210 days payment of payment receipt**
- Repayment taken from future claims
- Can repay in lump sum or will be taken from Medicare payments after 90 days
- IF not paid in full within 210 days, demand letter will be sent and interest will be charged at 9.625%
Summary: Non-face-face Services During COVID-19

1. Place of Service for ALL remote Non-face-to-face services = Typical POS 11-Office

2. IF not in office, indicate address in Block 32 of CMS 1500 form

3. Have **OPTION** of waiving copays and deductibles (cost sharing) for all non face-to-face services but will be paid 80% of Medicare allowable

4. **IF COVID-19 Related services**, file using –CS modifier and waive all cost sharing but will be paid 100% of Medicare allowable

5. Use -95 modifier for Telemedicine Services only

6. **ALL** Non-face-to-face services for New and established patients during the COVID-19 Public Health Emergency
Questions and Resources

• Submit additional questions to:

  https://www.aoa.org/ask-the-coding-experts

• Look for updates on additional Medicare coverage and payment information for telehealth services in AOA publications

• Review Guidance from AOA on COVID-19

  https://www.aoa.org/coronavirus

• Monitor any additional guidance from your Medicare Administrative Contractor (MAC)
THANK YOU!!!!

QUESTIONS????

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