RESOURCE AND PATIENT MANAGEMENT SYSTEM

Documentation, Coding, and Billing (Guidance for Coronavirus 2019)

(RPMS)

Configuration and Data Capture Guide

Version 1
April 2020

Office of Information Technology
Division of Information Technology

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Revision History

Version	Date	Author	Section	Page Number	Summary of Change
1	April 2020	National Council of Informatics	All Sections	All	Original publication
	April 2020	Janice Chase / Jacqueline Reyes	Coding Section	All	Editing introduction; adding Coding piece
	April 2020	Adrian Lujan / Robin Bartlett / Kathy Steele	All Sections	All	Original publication

Preface

This guide is for staff at IHS Tribal Urban (I/T/U) locations. As always, follow your local, state, and federal documentation, coding and reimbursement guidelines. Monitor all notices and publications from the Centers for Disease Control and Prevention (CDC), the Centers for Medicare and Medicaid Services (CMS), and State Medicaid offices.

This is an evolving guidance and will be modified as more information becomes available.

1.0 Introduction

Clinical Informatics, Health Information Management (HIM), Business Office (BO), and Office of Information Technology (OIT) subject matter experts (SMEs) have collaborated with this guidance to assist providers and staff to capture visit information during the COVID-19 pandemic.

Telemedicine/health services have been expanded and as new information is distributed by authorities this guide may become superseded.

Important:	It is emphasized that staff at the local level provide the best advice in determining how individual sites incorporate expanded services into their workflows due to the COVID-19 pandemic.

1.1 Disclosure of Current Procedural Terminology (CPT) Use

Application FARS/DFARS Restrictions Apply to Government Use

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CPT is commercial technical data and/or computer databases and/or commercial computer software and/or commercial computer software documentation, as applicable, which were developed exclusively at private expense by the American Medical Association (AMA), 330 N. Wabash Ave., Suite 39300, Chicago, IL 60611-5885.

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2.0 Coding for Coronavirus 2019 (COVID-19)

2.1 International Classification of Diseases Tenth Edition Clinical Modification (ICD-10-CM)

The CDC announced on March 30, 2020 the Final ICD-10-CM Official Coding and Reporting Guidelines for April 1, 2020 to September 30, 2020. The final guidance relates to the new Code U07.01 COVID-19.

Prior to April 1, 2020, the CDC ICD-10-CM Official Coding Guidelines – Supplement Coding encounters related to COVID-19 Coronavirus Outbreak effective February 20, 2020, did not include the new U07.01 COVID-19 Code.

When using the code U07.01 COVID-19, it is important to use additional codes to identify pneumonia or other manifestations. This excludes:

- Coronavirus infection, unspecified (B34.2)
- Pneumonia due to SARS-1 associated coronavirus (J12.81)

Do not code B34.2 Coronavirus infection, unspecified, for COVID-19, as this is documented to be a respiratory condition.

Important:	COVID-19 is a Coronavirus, but not all Coronaviruses are COVID-19.

Assign code U07.01 COVID-19 only for confirmed diagnosis as documented by the provider, documented positive COVID-19 test result or a presumptive positive COVID-19 test result. This is an exception to the hospital inpatient guideline Section II, H. In this context, “confirmation” does not require documentation of the type of test performed; the provider’s documentation that the individual has COVID-19 is sufficient. A presumptive positive test result means an individual has tested positive for the virus at a local or state level, but it has not yet been confirmed by the CDC. CDC confirmation to local and state test is no longer required.

Provider documentation must include:

- Confirmed positive test for COVID-19 for code U07.01

  If the provider documents suspected, possible, probable, or inconclusive do not assign code U07.01.

- Assign the code for the purpose of the visit, such as fever or Z20.828 contact with and (suspected) exposure to other viral communicable diseases.
- Associated respiratory conditions
- Identify if infection was present on admission

- Document comorbidities such as respiratory failures, ARDS, COD, etc.

2.1.1 COVID-19 in Pregnancy, Childbirth, and Puerperium

During pregnancy, childbirth, or the puerperium period, if a patient is admitted or presenting for visit because of COVID-19:

- Principle Diagnosis: O98.5, Other viral diseases complicating pregnancy, childbirth, and the puerperium
- Secondary diagnosis: U07.01 COVID-19 and the appropriate codes for associated manifestation(s).

Note: Codes from Chapter 15 always take sequencing priority.

Table 2-1: Coding Tips for ICD-10-CM

Prior to April 1, 2020	On April 1, 2020
Pneumonia confirmed as due to COVID-19: JI2.89 Other viral pneumonia B97.29 other Coronavirus as cause of diseases classified elsewhere	Pneumonia confirmed as due to COVID-19: U07.1 COVID-19 J12.89 Other viral pneumonia
Acute bronchitis confirmed as due to COVID-19: J20.8 Acute Bronchitis due to other specific organisms B97.29 Other Coronavirus as cause of disease classified elsewhere	Acute bronchitis confirmed as due to COVID-19: U07.1 COVID-19 J20.8 Acute bronchitis due to other specific organisms
Unspecified Bronchitis confirmed as due to COVID-19: J40 Bronchitis not specified as acute or chronic B97.29 Other Coronavirus as cause of diseases classified elsewhere	Unspecified Bronchitis confirmed as due to COVID-19: U07.1 COVID-19 J40 Bronchitis not specified as acute or chronic
Acute or lower respiratory infection confirmed as due to COVID-19: J22 Unspecified acute lower respiratory infection B97.29 Other Coronavirus as cause of diseases classified elsewhere	Acute or lower respiratory infection confirmed as due to COVID-19: U07.1 COVID-19 J22 Unspecified acute lower respiratory infection
Respiratory infection NOS confirmed as due to COVID-19: J98.8 Other specified respirator disorder B97.29 Other Coronavirus as cause of diseases classified elsewhere	Respiratory infection NOS confirmed as due to COVID-19: U07.1 COVID-19 J98.8 Other specified respirator disorder

ARDS confirmed as due to COVID-19: J80 Acute respiratory distress syndrome B97.29 Other Coronavirus as cause of diseases classified elsewhere	ARDS confirmed as due to COVID-19: U07.1 COVID-19 J80 Acute respiratory distress syndrome
Possible exposure to COVID-19, ruled out after evaluation: Z03.818 Encounter for observation for suspected exposure to other biological agents, ruled out	Possible exposure to COVID-19, ruled out after evaluation: Z03.818 Encounter for observation for suspected exposure to other biological agents, ruled out
Exposure to COVID-19 *NOT RULED OUT (exposed to someone with confirmed COVID-19):* Z20.828 Contact with and (suspected) exposure to other viral communicable disease.	Exposure to COVID-19 *NOT RULED OUT (exposed to someone with confirmed COVID-19):* Z20.828 Contact with and (suspected) exposure to other viral communicable disease.
Signs/Symptoms: If a definitive diagnosis has not been established, code only the signs and symptoms, i.e. cough, shortness of breath, fever, etc.	Signs/Symptoms: If a definitive diagnosis has not been established, code only the signs and symptoms, i.e. cough, shortness of breath, fever, etc.
Suspected/possible/probable COVID-19: Do not code B97.29. Use signs/symptoms or Z20.828	Suspected/possible/probable COVID-19: Do not code U07.1. Use signs/symptoms or Z20.828

For further CDC ICD-10-CM updates and announcements:

https://www.cdc.gov/nchs/icd/icd10cm.htm

2.2 American Medical Association (AMA) Current Procedural Terminology (CPT)

The AMA has published Special Coding Advice during COVID-19 Public Health Emergency. This includes 18 scenarios to assist providers and coders with Evaluation and Management (E&M) codes and a new CPT code for laboratory testing 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) CPT Assistant – Official Source for CPT Coding Guidance: AMA Fact Sheet: Reporting Severe Acute Respiratory Syndrome Coronavirus (SARS-CoV-2) Laboratory Testing, Special Edition-Volume 30, 2020.

A comparison reporting tool is also available: CPT Reporting for COVID-19 Testing.

2.3 CMS Healthcare Common Procedure Coding System (HCPCS)

CMS established Level II HCPCS codes, effective with line-item date of service on or after February 4, 2020:

- U0001 – CDC 2019 novel coronavirus (2019-ncov) real-time rt-pcr diagnostic panel
- U0002 – 2019-ncov coronavirus, sars-cov-2/2019-ncov (covid-19), any technique, multiple types or subtypes (includes all targets), non- CDC

The following two codes are effective March 1, 2020.

> **Note:** These two codes were distributed on 3/31/2020 by CMS and NOT available in RPMS; OIT will release an off-cycle CPT file expected by 4/30/2020).

- 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

2.4 Systematized Nomenclature of Medicine-Clinical Terms (SNOMED-CT)

On March 27, 2020, DTS Cycle 39 included two (2) mapped SNOMED-CT codes. For a complete update of SNOMED-CT, the interim release is available at:

SNOMED-CT information Systematized Nomenclature of Medicine-Clinical Terms (SNOMED-CT)

> **IMPORTANT:** Due to the timing of code set releases and development efforts, SNOMED and ICD COVID-19 codes are not completely mapped for the Electronic Health Record Integrated Problem List (IPL). The new ICD code of U07.1 was released in AUM V20 P2 but couldn't be mapped for the IPL. **Therefore, coders must enter the ICD U07.1 in the Patient Care Component (PCC). Reference Table 2-1 Coding Tips for ICD-10-CM.**

Table 2-2: Mapped SNOMED to ICD Codes in RPMS

Package	Release Date	SCTID	FSN	ICD 10 CM	ICD 10 CM Term
DTS Cycle 39	3/27/2020	840539006	Disease caused by 2019 novel coronavirus (disorder)	B97.29	Other coronavirus
DTS Cycle 39	3/27/2020	840546002	Exposure to 2019 novel coronavirus	Z20.828	Contact with and (suspected) exposure to other viral communicable diseases

2.5 Public Health Emergency – Telehealth

Any patient, regardless of where they are located, may receive telehealth services, such as nursing homes, hospital outpatient departments, patient's home, and other areas. This expansion is effective March 6, 2020 and is set for the duration of the COVID-19 Public Health Emergency. Telehealth is NOT restricted to COVID-19 diagnosis.

2.5.1 Definitions

- **Distant Site:** The site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system (where the provider is).
- **E-Visits:** A communication between a patient and their provider through an online patient portal.
- **Originating Site:** The location of the patient at the time the service furnished via a telecommunications system occurs (where the patient is). For the purpose of this public emergency, home will be temporarily allowed.
- **Telehealth:** A visit with a provider that uses telecommunication systems between a provider and a patient.
- **Virtual Check-in:** A brief check in with your provider via telephone or other communications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient. Virtual check-ins can be conducted with a broader range of communication methods, unlike Medicare telehealth visits, which require audio and visual capabilities for real-time communication. Effective March 30, 2020, doctors can provide these services to both new and established patients.

2.5.2 Different Types of Traditional Telehealth Delivery

- **Store-and-forward (Asynchronous):** Acquiring and storing clinical information (data, images, sound, etc.) that is forwarded (or retrieved by) another site for clinical evaluation.
- **Real-time (Live Synchronous) interactive:** Interactive audio and video telecommunications systems that permits real-time communication between the provider and the patient.

Table 2-3: Telehealth Coding

Type of Service	HCPCS/CPT Codes
Telehealth	**99201-99215** – (office or other outpatient visits) For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-codes **G0425-G0427** – (Telehealth consultation, emergency department or initial inpatient). **G0406-G0408** – (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs).
Virtual Check-In	Virtual Check-In services, or brief check-ins between a patient and their doctor by audio or video device, could previously only be offered to patients that had an established relationship with their doctor. **Effective March 30, 2020, doctors can provide these services to both new and established patients.** https://www.cms.gov/newsroom/fact-sheets/additional-backgroundsweeping-regulatory-changes-help-us-healthcare-system-address-covid-19-patient Check third party billing guidelines for new patients using virtual check-in service for the appropriate code and/or modifier. **New or Established Patient – Telephone:** **99441:** Telephone evaluation and management service provided by a physician 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. **99442:** Telephone evaluation and management service provided by a physician 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; 11-20 minutes of medical discussion. **99443:** Telephone evaluation and management service provided by a physician 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; 21-30 minutes of medical discussion. **For non-physician services, such as optometry, Behavioral Health** **98966:** Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion. **98967:** Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion. **98968:** Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion. **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. **G2012** – The practitioner may respond to the patient's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal.
E-Visits	Medicare Part B also pays for E-visits or patient-initiated online evaluation and management conducted via a patient portal. Practitioners who may independently bill Medicare for evaluation and management visits (for instance, physicians and nurse practitioners) can bill the following codes: **New or Established Patients:** **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. **99422** – Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 11– 20 minutes.

	99423 – Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes. Clinicians who may not independently bill for evaluation and management visits (for example – physical therapists, occupational therapists, speech language pathologists, clinical psychologists) can also provide these e-visits and bill the following codes: **G2061** – Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5–10 minutes. **G2062** – Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11–20 minutes. **G2063** – Qualified non-physician qualified healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes.

2.5.3 Telehealth Service Modifiers

Telehealth modifiers, shown in Table 2-4, must be submitted with distant site telehealth services. Generally, interactive audio and video communications must be used to permit real-time communication between distant site physician/practitioner and patient. Patient must be present and participating in telehealth visit.

CMS requires use of modifier 95 for telehealth services; other payors may require its use. The CMS guidance is available at:

https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-03-mlnc-se

Table 2-4: Telehealth Service Modifiers, source: Novitas Solutions

Modifier	Description
G0 (zero)	Telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke. Effective for claims with dates of service on and after January 1, 2019, modifier G0 is valid for: • Telehealth distant site codes billed with Place of Service (POS) code 02; or • Critical Access Hospitals, CAH method II (revenue codes 096X, 097X, or 098X); or • Telehealth originating site facility fee, billed with HCPCS code Q3014

Modifier	Description
GQ	Telehealth service rendered via asynchronous telecommunications system.
GT	Via interactive audio and video telecommunication systems • Effective January 1, 2018, the use of modifier GT on professional claims has been eliminated. Use of the telehealth POS code 02 certifies that the service meets the telehealth requirements. • Effective October 1, 2018, the GT modifier is only allowed on institutional claims billed by CAH Method II providers.

Coders should communicate with their EHR team on how visits are being set up to ensure seamless workflows for subsequent coding and billing. Refer to Section 2.6, Definitions.

2.5.4 Telehealth Documentation

Providers will continue to document the visit in the same manner as a face-to-face encounter:

- Patient agrees to telehealth visit and understands that CISCO meeting is a secured connection or unsecure if using Apple FaceTime, Skype, etc.
- Location of the Patient and the Provider
- All persons participating and their role in the encounter
- Start and end times

For example:

> "Patient FIRST LAST NAME presents via CISCO MEETING on MM/DD/YY. Provider FIRST LAST NAME was located at the LOCATION (I/T/U FACILITY NAME, HOME). Patient FIRST LAST NAME was located at LOCATION (HOME). Patient verbally consents to the use of telemedicine for this visit and acknowledges this is a secure platform. Guardian/spouse is present with the patient during the visit."

Figure 2-1 is an example of a Virtual Check-In Template:

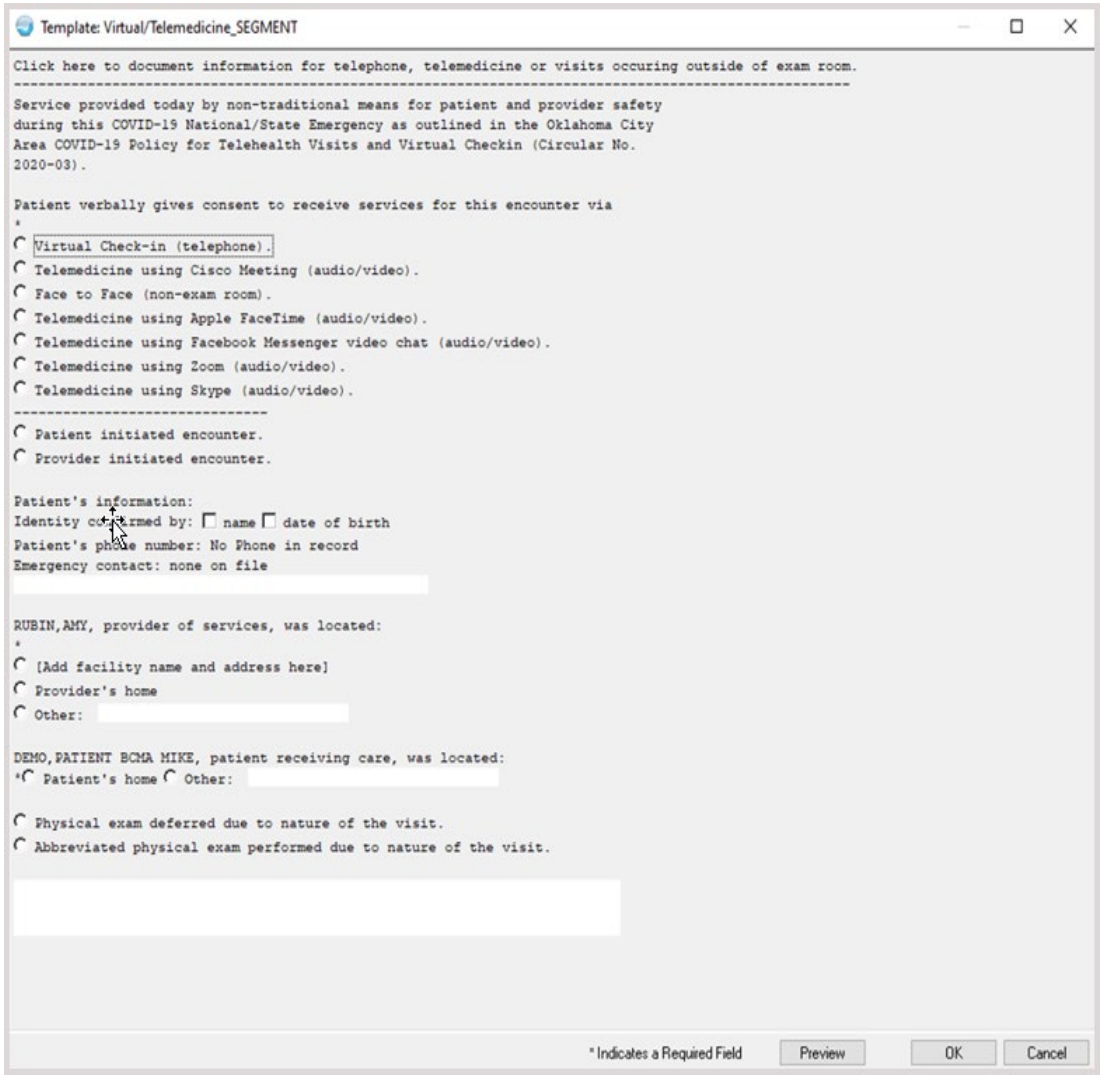

Figure 2-1 Virtual Check-In Documentation Template

2.5.5 COVID-19 Evaluation and Management Documentation

- Chief complaint.

  Fever, flu exposure, COVID-19 exposure, shortness of breath, cough, sore throat, body/muscle aches, sinus pains, chills.

- History and Physical.
  - Onset / duration.

    Documented if exposure to COVID-19 is suspected, confirmed or unknown, recent travel (number of days and location), severity, pail level, is condition worsened by deep breath.

  - Symptoms and Vitals.
  - Review of Systems.
  - Past medical history (allergies, immunizations, etc.).
  - Social and Family history.
- Physical exam (deferred for telehealth).
- X-ray (chest x-ray or CT chest) and lab results (CB, Chemistries, UA, COVID-19, flu etc.). For telehealth document any previous x-ray or lab or if such will be ordered for patient.
- Interventions and Treatment plan for flu or COVID-19 suspected or positive patients.
- Clinical Impression/Final Diagnosis: asthma, reactive airway disease, bronchitis, COPD, pharyngitis, pneumonia specificity (interstitial, atypical, viral, bacterial, COVID-19), sinusitis, COVID-19 suspected, exposure, confirmed, etc.
- Medications, education, counseling, and disposition.
- Signature, date, and time.

It should be understood this guide doesn't replace the rules contained within any official coding guideline.

2.6 IHS Coding Listserv

The IHS Coding Listserv is an available tool for I/T/U coders to use for troubleshooting coding scenarios, HER, and other coding process changes, and for general assistance with coding/billing compliance feedback.

Request to join the listserv at this link:

https://www.ihs.gov/listserv/topics/signup/?list_id=129

Coding Listserv:

To send an email to the list: CODING@LISTSERV.IHS.GOV

3.0 Introduction to the Toolkit

IMPORTANT: Coordinate with your EHR Team to carefully delineate specific workflow and business processes for your facility as not all of the RPMS/EHR Setup and Configuration will apply to your processes.

If you are unsure of how to do any of the steps outlined in this section, contact your Area support team or join OIT EHR Office Hours for assistance.

3.1 Definitions

Table 3-1 displays the services offered with telemedicine, the definitions of each service and its modality.

Table 3-1: Types of Telemedicine Service and Definitions

Type of Service	What is the Service? (per CMS)	Modality
Virtual Check-In	A brief check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	Audio only medical services
Telemedicine	A visit with a provider that uses telecommunication systems between a provider and a patient.	Audio-visual medical services
E-Visit	A communication between a patient and their provider through an online patient portal.	Personal Health Record (PHR) and DIRECT secure messaging
Virtual Check-In BH	A brief check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	Audio only Behavioral Health services
Telebehavioral Health	A visit with a provider that uses telecommunication systems between a provider and a patient.	Audio-visual Behavioral Health services
E-Visit BH	A communication between a patient and their provider through an online patient portal.	Personal Health Record (PHR) and DIRECT secure messaging

3.2 Toolkit Materials/References

Toolkit materials and references are available as follows:

- Medicare Telemedicine Health Care Provider Fact Sheet. Select this link:

  https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

- EHR Progress Note Templates Folder:
  - Virtual Check-in/Telemedicine SEGMENT.txml
  - Virtual Check-in/Telebehavioral Health SEGMENT.txml
- Patient Education Picklists Folder:
  - EHR Patient Education Picklist: **Communicable Diseases.zge**
  - EHR Patient Education Picklist: **Influenza.zge**
- SNOMED Picklists Folder:
  - EHR Problem Management Integrated Problem List SNOMED Picklist: **COVID-19.zgp**
- CPT Picklists Folder:
  - Excel File with Telemedicine CPT Codes: **Medicare_telehealth_code_list_for_cy_2019_and_2020_rab.xlsx**
  - Word Document with EHR Superbill CPT Picklist Screen Shots: **EHR Superbill CPT Picklists.docx**
  - EHR Superbill CPT Picklist: **Virtual Check-In.zgs**
  - EHR Superbill CPT Picklist: **Virtual E-Visits.zgs**
  - EHR Superbill CPT Picklist: **Telemedicine.zgs**
  - EHR Superbill CPT Picklist: **Telebehavioral Health.zgs**
  - EHR Superbill CPT Picklist: **Tele-Inpatient-ER Followup.zgs**

3.3 Telemedicine RPMS/EHR Setup and Configuration Checklist

1. Review RPMS/EHR Parameters

   - ☐ **Selectable Visit Types**
   - ☐ **RPMS PCC EHR Coding Queue Parameter: CASP**
   - ☐ **RPMS Third-Party Billing Configuration Guide**

2. Create Clinics in Practice Management Application Suite

- ☐ **Virtual Check-In**
- ☐ **Telemedicine**
- ☐ **E-Visit**
- ☐ **Virtual Check-In BH**
- ☐ **Telebehavioral Health**
- ☐ **E-Visit BH**

3. Create Note Titles

   - ☐ **Virtual Check-In**
   - ☐ **BH Virtual Check-In – (Ensure under appropriate BH business rules document class)**
   - ☐ **Telemedicine**
   - ☐ **Telebehavioral Health – (Ensure under appropriate BH business rules document class)**
   - ☐ **E-Visit**
   - ☐ **BH E-Visit – (Ensure under appropriate BH business rules document class)**

4. Create Progress Note Templates

   - ☐ **Virtual Check-In**
   - ☐ **Telemedicine**
   - ☐ **Telebehavioral Health**
   - ☐ **E-Visit**

5. Create EHR Quick Note Button

   - ☐ **Virtual Check-In Medical**
   - ☐ **Virtual Check-In Behavioral Health**
   - ☐ **Telemedicine**
   - ☐ **Telebehavioral Health**
   - ☐ **E-Visit**
   - ☐ **E-Visit Behavioral Health**

6. Develop/Import Patient Education Picklists

   - ☐ **Communicable Diseases**
   - ☐ **Influenza**

7. Develop/Import EHR Problem Management – Integrated Problem List – SNOMED Picklist

   - ☐ **COVID-19 (more coronavirus specific SNOMED terms to be released)**

8. Develop/Import EHR Superbill CPT Pick Lists

   - ☐ **Virtual Check-In**
   - ☐ **Virtual E-Visit**
   - ☐ **Telemedicine**
   - ☐ **Telebehavioral Health**
   - ☐ **Tele-Inpatient-ER Follow-up**

IMPORTANT:	Coordinate with your EHR Team to carefully delineate specific workflow and business processes for your facility, as not all of the RPMS/EHR Setup and Configuration will apply to your processes.

4.0 Clinic Codes

An abbreviated list of clinic codes is displayed in Table 4-1. It includes the service/specialty being provided, as well as the description.

Table 4-1: Clinic Codes

Code	Name	Description	Status
01	General	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides acute, chronic and preventive medical care to all age groups on an appointment or walk-in basis.	Available
28	Family Practice	Feb 18, 2005 Approved by Medical Records. An organized clinic providing family medical services through family practice-trained providers.	Available
D7	Online Services	Feb 18, 2005 Approved by Medical Records. Contact with individuals over the internet for a medically significant intervention using the Personal Health Record or Direct Messaging.	Available
C4	Behavioral Health	Feb 18, 2005 Approved by Medical Records. An organized clinic that focuses on behavioral health services such as mental health, alcohol and substance abuse, and social services to children, adolescents, adults and their families. Services include assessment, group or individual therapy and where needed, medication management.	Available
C9	Telebehavioral Health	Feb 18, 2005 Approved by Medical Records. The provision of behavioral health services via videoconferencing and/or other recognized forms of telemedicine (e.g. store-and-forward software). Services include assessment, individual/couples/family/group therapy, medical management, clinical case consultation, and case management. Conventional telephone consultation alone does not constitute telebehavioral health.	Available
90	Telemedicine	Feb 18, 2005 Approved by Medical Records. The provision of consultant services by off-site physicians to health care professionals on the scene, as by means of closed-circuit television.	Available

Code	Name	Description	Status
51	Telephone Call	Feb 18, 2005 Approved by Medical Records. Contacts with individuals over the telephone for a medically significant intervention.	Available
52	Chart Rev/Rec Mod	Feb 18, 2005 Approved by Medical Records. Review of the medical record, resulting in documentation of a medically significant condition; absent a direct patient visit.	Available
25	Other	Feb 18, 2005 Approved by Medical Records. Any specialty organized clinic not otherwise identified (Do not use for after-hours clinics. Refer to clinic code 89).	Available

Table 4-2 displays the Public Health Emergency code, which will be available in a future patch to be released in April 2020.

Table 4-2: Public Emergency Code

Code	Name	Description	Status
Code	Name	Description	Status
E8	Public Health Emergency	A clinic that provides health services in response to a public health emergency at the national, regional, or local level. Such as, but not limited to, epidemic, pandemic or natural disasters.	NEW Now Available (AUM v20.0 p2)

A full list of RPMS/EHR Clinic Codes is available at the IHS Standard Code Book reference link:

https://www.ihs.gov/SCB/index.cfm?module=W_CLINIC&option=list&num=81&newquery=1

5.0 Service Category

Service categories, displayed in Table 5-1, are used to describe how a service is provided.

Table 5-1: Service Categories

Code	Name	Description	Status
A	Ambulatory	Used for workload.	Available
E	Historical (Event)	Used to document past events. Not used for workload.	Available
T	Telecommunications	Used to document informal patient encounters such as telephone conversations. Not used for workload.	Available
C	Chart Review	Used to document chart reviews. Not used for workload.	Available
I	In-Hospital	Used to document ambulatory visits on hospitalized patients.	Available
S	Day Surgery	Used to document Day Surgery visits.	Available
R	Nursing Home	Used to document nursing home visits.	Available
N	Not Found	Used for service categories not otherwise specified.	Available
M	Telemedicine	Used to document telemedicine visits.	Available

A full list of RPMS/EHR Service Categories is available at the IHS Standard Code Book reference link:

https://www.ihs.gov/SCB/index.cfm?module=W_SVC_CATEGORY&option=list&num=66&newquery=1

6.0 Review RPMS-EHR Parameters

☐ **Selectable Visit Types**

- BEHO – ENC – TYP or
- XX Parameter: BEHOENCX VISIT TYPES
- Ensure "M~Telemedicine~Used to document telemedicine visits." is included.
  - Division vs. System level may vary from site to site.
  - Division level setup is preferred with this parameter.
- Once included within parameter, Telemedicine Type of Visit will be selectable in EHR when creating a New Visit.

☐ **RPMS PCC EHR Coding Queue Parameter: CASP**

- PCC – ENT – ERHC – CASP Update EHR Coding Audit Site Parameters
  - Menu pathways may differ from site to site
  - Coordinate with HIM (Health Information Management) staff as menu options may be restricted by security key access.

☐ **RPMS Third Party Billing Configuration Guide**

- Reference to Third Party Billing Configuration Guide Section 12.0

6.1 Selectable Visit Types

1. Select the RPMS-EHR Configuration Master Menu option, **ENC Encounter Context Configuration**./

```
                    RPMS-EHR Configuration Master Menu

ART     Adverse Reaction Tracking Configuration ...
CCD     CCDA Component Configuration ...
CCX     Chief Complaint Configuration ...
CON     Consult Tracking Configuration ...
EDU     Patient Education Configuration ...
ENC     Encounter Context Configuration ...
EPCS    IHS EPCS Main Menu ...
EXM     Exam Configuration ...
FRM     VueCentric Framework Configuration ...
HFA     Health Factor Configuration ...
IMM     Immunization Configuration ...
LAB     Lab Configuration ...
MED     Medication Management Configuration ...
NOT     Notification Configuration ...
ORD     Order Entry Configuration ...
PAT     Patient Context Configuration ...
PHX     Personal Health Hx Configuration ...
PLS     Problem List Configuration ...
POV     POV Configuration ...
PRC     Procedure Configuration ...
```

```
REM    Reminder Configuration ...
RPT    Report Configuration ...

            Press 'RETURN' to continue, '^' to stop:
SPL    Spellchecking Configuration ...
TIU    TIU Configuration ...
VIT    Vital Measurement Configuration ...
```

Figure 6-1: Encounter Context Configuration (ENC) option

2. Select the Encounter Context Configuration option, **TYP Selectable Visit Types**.

```
CRT    Allow User to Create New Visits
LCK    Days After Which Visit is Locked
OTH    General Location for Outside Encounters
OVR    Temporarily Override Visit Lock for User
PRV    Allow a User to be a Visit Provider
STP    Visit Search Stop Date
STR    Visit Search Start Date
TYP    Selectable Visit Types
```

Figure 6-2: Selectable Visit Types (TYP) option

3. Set the Selectable Visit Type for the division, DEMO SERVICE UNIT.

```
                          Selectable Visit Types

Selectable visit types may be set for the following:

     5    Division       DIV    [DEMO SERVICE UNIT]
     10   System         SYS    [DEMO-HC.NSH.IHS.GOV]

Enter selection: 5    Division    DEMO SERVICE UNIT
```

Figure 6-3: Demo Service Unit option

> **Note:** The Division setting may vary depending on how the site was set up.

4. At Select Sequence, type a **question mark** (?), then view the options to ensure **M~Telemedicine~Used to document telemedicine visits** is there. If not, it must be added.

```
Select Sequence: ?
Sequence  Value   <Inpatient Facilities will have additional hospital
related options>
------------  -------
1         A~Ambulatory~Used for workload
2         E~Historical~Used to document past events. Not used for workload
3         T~Telephonic~Used to document informal patient encounters such as
             telephone call    Not use for workload
4         C~Chart Review~Used to document chart reviews    Not used for
             workload
9         N~Not Found~Used for service categories not otherwise specified
10        M~Telemedicine~Used to document telemedicine visits
```

Figure 6-4: Select Sequence screen

6.2 RPMS PCC EHR Coding Queue Parameter (CASP)

1. Select the PCC Manager Menu option, **PCC Patient Care Data Entry Menu**.

```
                        **********************************
                        **    PCC Data Entry Module     **
                        **********************************
                            IHS PCC Suite Version 2.0
                            DEMO SERVICE UNIT
```

Figure 6-5: PCC Data Entry Module screen

2. Select Patient Care Data Entry Menu option, **ENT Enter/Modify/Append PCC Data**.

```
ENT     Enter/Modify/Append PCC Data ...
DSP     Display Data for a Specific Patient Visit
PEF     Print a PCC Visit in Encounter Form format
UPD     Update Patient Related/Non Visit Data ...
DEU     Data Entry Utilities ...
VIEN    Display a Visit by Visit IEN
BHS     Browse Health Summary
DVB     Display a PCC Visit w/limited Lab Display
GHS     Generate Health Summary
PDV     Print a PCC Visit Display to a Printer
```

Figure 6-6: Enter/Modify/Append PCC Data (ENT) option

3. Select the Enter/Modify/Append PCC Data option, **EHRC EHR/PCC Coding Audit Menu**.

```
                  ******************************************
                  **        PCC Data Entry Module         **
                  **      Enter PCC Data Menu Options     **
                  ******************************************
                            IHS PCC Suite Version 2.0
                            DEMO SERVICE UNIT

MIN     Data Entry Using Mnemonics
```

```
   ENT     Enter Data
   MOD     Modify Data
   APP     Append Data To An Existing Visit Record
   APL     Append Data using Item List Display
   TIM     Modify Visit Date and/or Time
   EAC     Enter Data with Visit Display and Actions
   MNE     Enter PCC Data Using Item List Display
   GRP     Group Preventive Form Entry
   HIN     Enter Historical INPATIENT Visits
   DTC     Tran Code (DTC) Entry for All Visits
   TCH     Enter Trans Codes on IN-Hospital Visits
   TCO     Enter Trans Codes on Outpatient Visits
   DMU     Update Diabetes Patient Data
   EC      Entry of Data for a Cohort of Patients
   MFC     Display a Count of Forms you have Processed
   SF      Enter/Edit Suicide Forms ...
   EHRC    EHR/PCC Coding Audit Menu ...
   LOG     Enter Data From LOGS (lab/rad/cpt/apc) ...
   RSPV    Resequence Purpose of Visits (POVs) on a Visit
```

Figure 6-7: EHR/PCC Coding Audit Menu (EHRC) option

4. Select the EHR/PCC Coding Audit Menu option, **CASP Update EHR Coding Audit Site Parameters**.

```
   EHRD    EHR/PCC Coding Audit for Visits in Date Range
   PEHR    EHR/PCC Coding Audit for One Patient
   ACDR    Add new Chart Deficiency Reason to Table
   TUR     Count Unreviewed Visits by Date/Service Category
   ACCL    Auto Mark Visits as Reviewed/Complete by Clinic
   ACRX    Auto-Complete Pharmacy Education Only Visits
   CASP    Update EHR Coding Audit Site Parameters
   ICPD    Incomplete Charts by Provider w/Deficiencies
   INCV    List Visits Marked as Incomplete
   LIR     List Unreviewed/Incomplete Visits
   TRV     Tally of Reviewed/Completed Visits by Operator
   TRVL    Tally Reviewed/Completed Visits (Last Operator)
   VNR     Tally/List of Visits not Reviewed in N Days
```

Figure 6-8: Update EHR Coding Audit Site Parameters (CASP) option

EHR Coding Queue Parameter Review

Review the EHR Coding Queue Parameter to ensure Telemedicine service category is NOT listed under the highlighted section. Your site is currently set up to exclude visits with the following service categories from the coding queue:

```
Select PCC DATA ENTRY SITE PARAMETERS SITE NAME: DEMO SERVICE UNIT
        NASHVILLE NON-IHS       DEMO SERVICE UNIT       30    TX  MC(M)
9999

Service Category exclusions: If you would like to exclude visits with a
particular service category from the list of visits displayed in the coding
queue you must enter those service categories to the list below. For
example, if you do not wish to have I - In Hospital visits in the list,
then you should add 'I' to the list.
Please note: If you leave the list blank (empty) then all direct (non-CHS)
visits will display in the coding queue.
```

```
Historical EVENT visits never display in the coding queue.

Your site is currently set up to exclude visits with the following service
categories from the coding queue:

None selected, All visit service categories will be included in the coding
queue.

     Select one of the following:

          A         Add another service category to the list
          R         Remove a service category from the list
          Q         Quit - list looks good

Do you wish to: Q// uit - list looks good

You have the option of seeing all visits in the coding queue regardless of
how they were created. You can see all visits or limit the list of visits
in the coding queue to only those on which a provider has been entered. If
you choose to only see visits on which a provider was entered then you will
not see visits that were created by an ancillary package. Most, if not, all
visits created by EHR users will have provider.

< IMPORTANT: Coordinate any modifications to EHR Coding Queue Parameters
with facility Health Information Management Director. May vary based on
local policies and procedures.>

Include all visits in the coding queue list?: Y  YES, INCLUDE VISITS WITH
NO PROVIDER

Default Response for 'Is Coding Complete?' in Data Entry: N  NO

Require Chart Deficiency Reason on Visits marked as Incomplete?: Y  YES

Number of days to chart w/ deficiencies is delinquent: 3
```

Figure 6-9: Coding Queue Parameter screen

7.0 Create/Review Clinics

7.1 Clinic Workflow Considerations

IMPORTANT:	Coordinate with your EHR Team to carefully delineate specific workflow and business processes for your facility, as not all of the RPMS/EHR Setup and Configuration will apply to your processes.

- Workflow may or may not dictate the need for additional clinics to be created.
- Workflows could use existing clinics with appropriate documentation management.
  - Service Category code must be Telemedicine (M) for Virtual Check-in, Telemedicine, and E-Visit types of service.
  - May change clinics to uncheck Create Visit at Check-in within clinic setup in Practice Management Application Suite (BPRM) and have providers create new visit with Telemedicine Type of Visit through visit selection New Visit option or EHR Quick Notes.
  - May have coder change service category on back end from Ambulatory to Telemedicine Service Category within EHR Coding Queue VST mnemonic if using a provider's existing clinic.

7.2 Review Clinics in Practice Management Application Suite

Identify any modifications or additional clinics needed.

Examples:

- ☐ **Virtual Check-In**
- ☐ **Telemedicine**
- ☐ **E-Visit**
- ☐ **Virtual Check-In BH**
- ☐ **Telebehavioral Health**
- ☐ **E-Visit BH**

Table 7-1: Clinic Name – Clinic Code – Service Category Summary Table

Clinic Name	Clinic Code	Service Category
Blue Team (existing clinic example)	General (01)*	Telemedicine (M)
Virtual Check-In	General (01)*	Telemedicine (M)
Telemedicine	Telemedicine (90) *	Telemedicine (M)

Clinic Name	Clinic Code	Service Category
E-Visit	Online Services (D7)	Telemedicine (M)
Virtual Check-In BH	Behavioral Health (C4)	Telemedicine (M)
TeleBehavioral Health	TeleBehavioral Health (C9)	Telemedicine (M)
E-Visit BH	Online Services (D7)	Telemedicine (M)
* Can also be applicable clinic code based on services provided.		

- Based on workflow, clinics may be needed for each individual provider to manage scheduling. If workflow indicates the need for a new clinic(s), use Section 7.2.1 and Section 7.2.2 as guides to help create the new clinic(s).
- Carefully consider using established clinics to accommodate existing workflow.

7.2.1 Create New Clinic: Virtual Check-In

Figure 7-1 displays how to create a new Virtual Check-In clinic.

1. On the Create New Clinic window, type **Virtual Check-In** in the Name field.
2. Click **Save**.

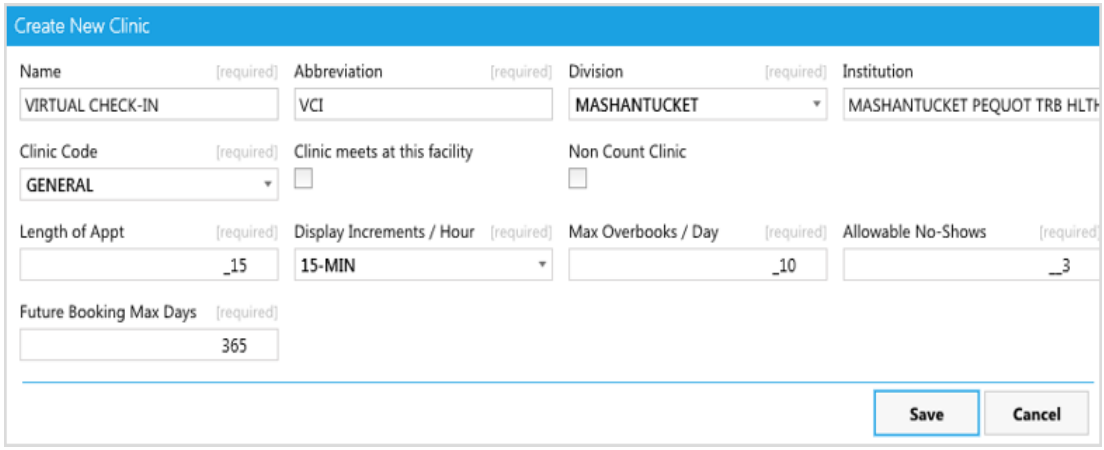

Figure 7-1: Create New Virtual-Check-In Clinic window

The Clinic Configuration window (Figure 7-2) General tab displays.

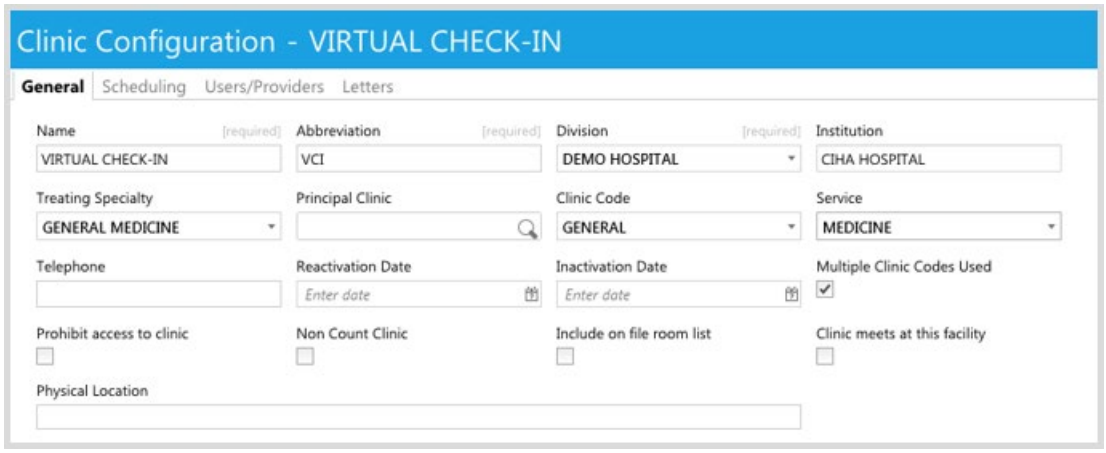

Figure 7-2: Clinic Configuration Virtual Check-in window

3. Ensure the GENERAL clinic code is selected within clinic configuration.
4. Ensure the Multiple Clinic Codes Used checkbox is selected.
5. Select the Scheduling tab. The Clinic Configuration Scheduling window (Figure 7-3) displays.

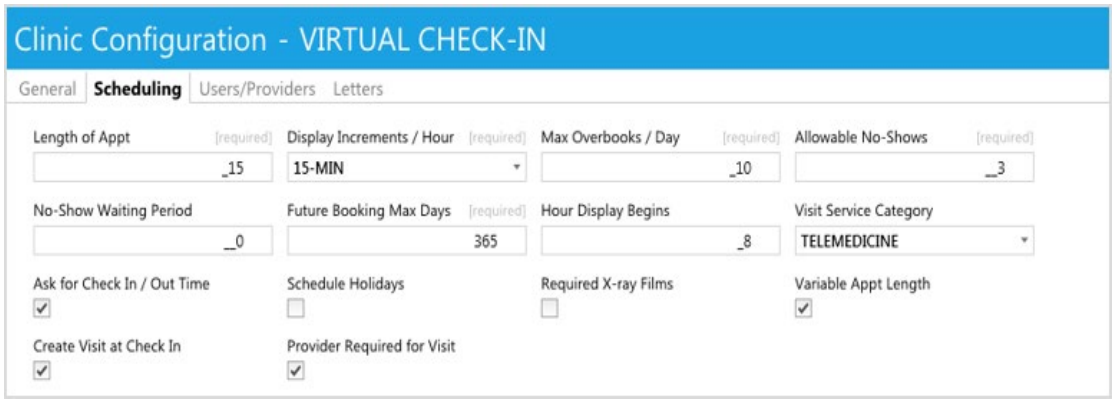

Figure 7-3: Clinic Configuration Scheduling window

6. Complete the appropriate fields.
7. Select the Users/Providers tab. The Clinic Configuration User Providers window (Figure 7-4) displays.

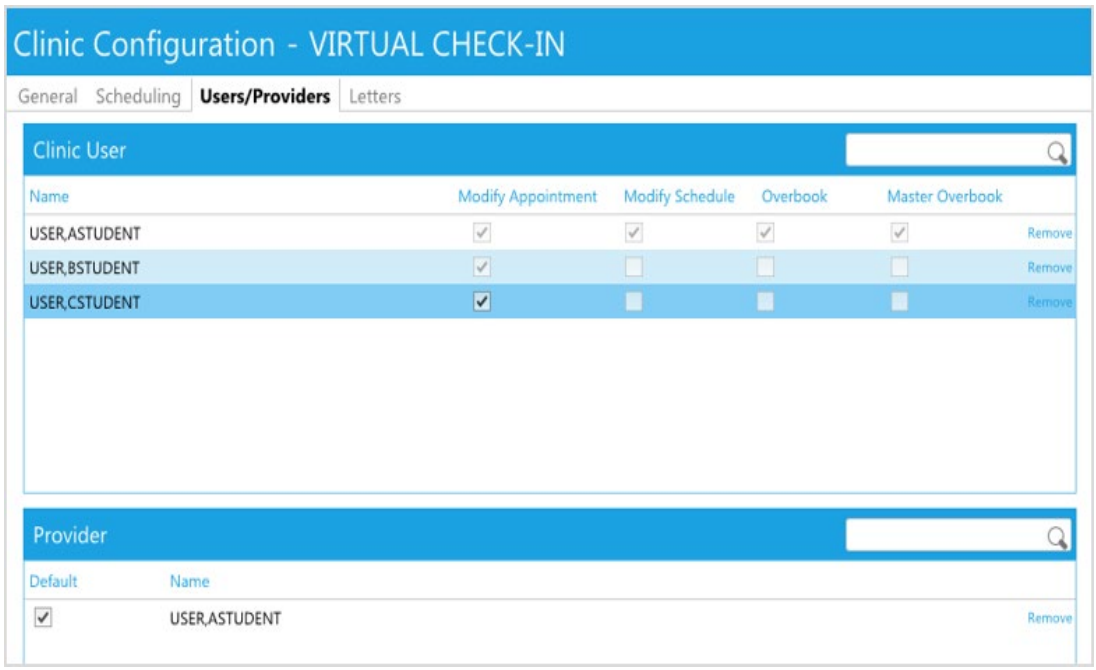

Figure 7-4: Clinic Configuration User Providers window

8. Save the Clinic Configuration.
9. Select the clinic created from Clinic list.
10. Click Edit Availability to define possible appointment schedule.

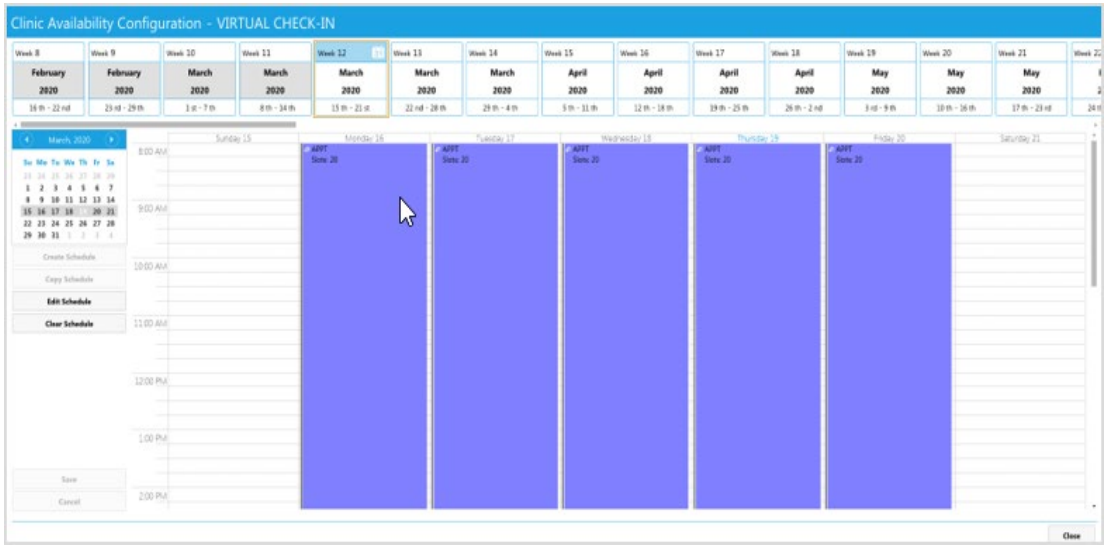

Figure 7-5: Clinic Availability Configuration window

11. Customize the Clinic Availability Configuration to match the service schedule. You may need to add additional clinics based on the number of providers.

7.2.2 Create New Clinic: E-Visit

1. On the Create New Clinic window (Table 7-1), type **E-VISIT** in the Name field and complete appropriate fields.

2. Click **Save**.

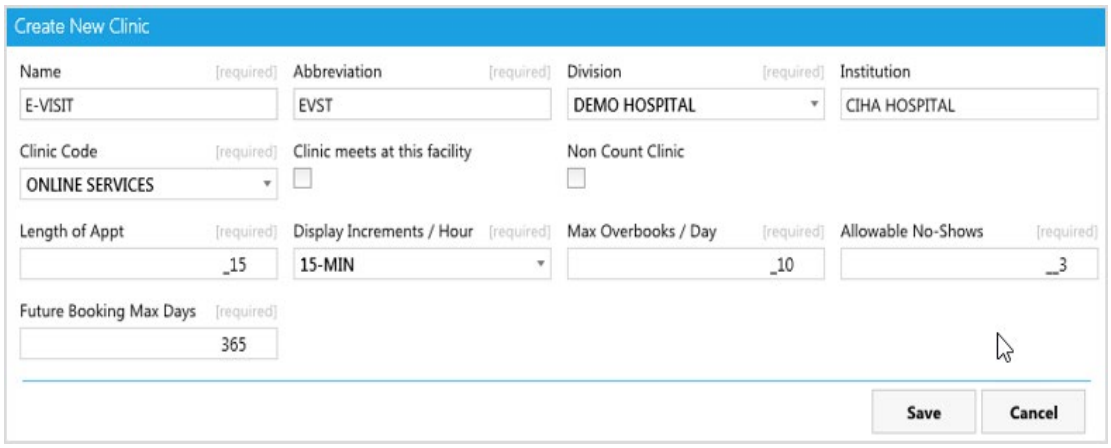

Figure 7-6: Create New E-Visit Clinic window

The Clinic Configuration window (Figure 7-7) General tab displays.

Figure 7-7: Clinic Configuration E-Visit General Tab window

3. Ensure the Online Services clinic code is selected within E-VISIT clinic configuration.

4. Select the Scheduling tab. The Clinic Configuration Scheduling window (Figure 7-8) displays.

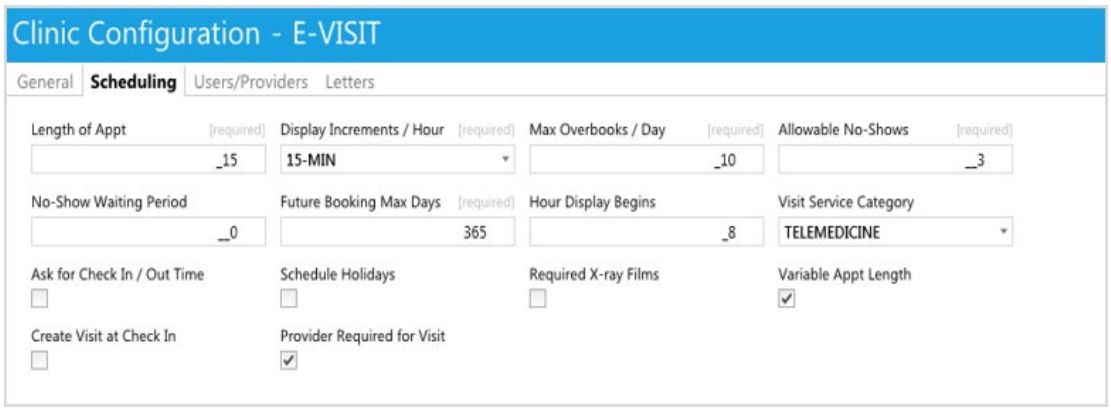

Figure 7-8: Clinic Configuration E-Visit Scheduling Tab window

5. Complete the appropriate fields.

   a. Ensure Telemedicine Visit Service Category is selected.

   b. Do not check Ask for Check In/Out Time or Create Visit at Check In for this type of E-VISIT clinic creation.

6. Select the Users/Providers tab. The Clinic Configuration Users/Providers window (Figure 7-9) displays.

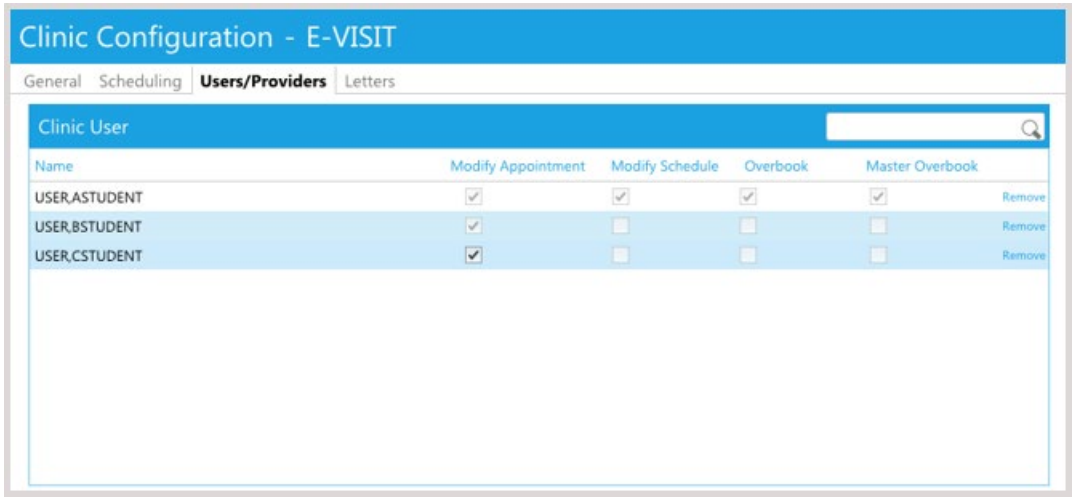

Figure 7-9: Clinic Configuration E-Visit Users/Providers Tab window

> **Note:** Clinic Availability Configuration is not needed for an E-Visit, since all visits will be created in EHR with the EHR Quick Note button.

8.0 Create New Note Titles: Virtual Check-In and Telemedicine

IMPORTANT:	Coordinate with your EHR Team to carefully delineate specific workflow and business processes for your facility, as not all the RPMS/EHR Setup and Configuration will apply to your processes.

When creating new Note Titles, follow your local processes. It is recommended that HIM and EHR teams are involved in decision making. Carefully consider using existing note titles to accommodate workflow. Example menu path:

– **BEHO** RPMS EHR Configuration Master Menu – **TIU** Configuration – **HIS** TIU Menu for Medical Records – **TMM** TIU Maintenance Menu – **DDM** Document Definitions Manager – **DDM 3** – Create Document Definitions

Place new note titles in the appropriate document class used for your clinical note titles. No need to create a new document class.

Table 8-1 displays possible note titles and mapping.

Table 8-1: Note Titles and Mapping

NOTE TITLE	VHA ENTERPRISE STANDARD TITLE MAP
VIRTUAL CHECK-IN	TELEPHONE ENCOUNTER NOTE
TELEMEDICINE	TELEMEDICINE NOTE
E-VISIT	CORRESPONDENCE

Note:	If creating new behavioral-health related note titles, ensure they align with current behavioral-health note titles, document classes, and any potential business rules if applicable. Business rules can be used to create different levels of confidentiality for behavioral health notes.

The following is the link to resources on behavioral-health business rules:

https://www.ihs.gov/sites/rpmsbh/themes/responsive2017/display_objects/documents/EHRBHTierIandIIBusRules.pdf

Possible behavioral health note titles and mapping:

Table 8-2: Behavioral Health Note Titles and Mapping

NOTE TITLE	VHA ENTERPRISE STANDARD TITLE MAP
BH VIRTUAL CHECK-IN	MENTAL HEALTH TELEPHONE ENCOUNTER NOTE
TELEBEHAVIORAL HEALTH	MENTAL HEALTH TELEMEDICINE NOTE
BH E-VISIT	CORRESPONDENCE

9.0 Create/Import EHR Progress Note Templates

RPMS EHR Note Templates for documenting Virtual Check-in, Telemedicine, and Telebehavioral Encounter Requirements during COVID-19 public health emergency:

There are many considerations for documentation requirements that are evolving during this COVID 19 public-health emergency. Follow CMS, State, and local guidance for specifics.

Two note-template segments delivered:

- Virtual Check-in/Telemedicine_SEGMENT.txml
- Virtual Check-in/Telebehavioral_SEGMENT.txml

Suggested use cases for incorporating note-template segment:

1. Add note template segment only to EHR quick note button configuration.
    a. Provider can then use their desired template.
2. Add note-template segment to each identified provider's individual template.
3. Make note-template segment available in Shared Templates folder to pull into note as needed.

Steps for incorporating note-template segment:

- Import in note templates.
- Informaticists will need to edit the TIU Template Field called:
  {FLD:OCA TM LOC PRV} to add their facility information.
- Identify templates to add segment to:
    - Export out existing template (will need to save as is for future use)
    - Import template in and append name to differ from original template
    - Add to template:
        - Time based codes: include start time and stop time
        - Virtual Check-in (telephone): time spent in medical discussion with the patient (minutes): ____
    - Make other identified edits to accommodate documentation for these types of visits:
        - If two patient identifiers are in the template, should be removed from the segment being added
        - Other examples: remove vitals, edit physical exam

  - Do NOT include messages about billable encounters or data charges within legal health record; may consider adding a statement into newsletters, flyers, audio-video invitation information, etc.

- Optional use of activity time for providers (required for behavioral health and public health nurses):
  - Add time to activity time to become part of visit file
  - Consider adding this first and pulling information into note with data object
- Carefully review template in conjunction with Health Information Management (HIM), clinicians, and billing team members for other needed changes.
- Inform and train providers.

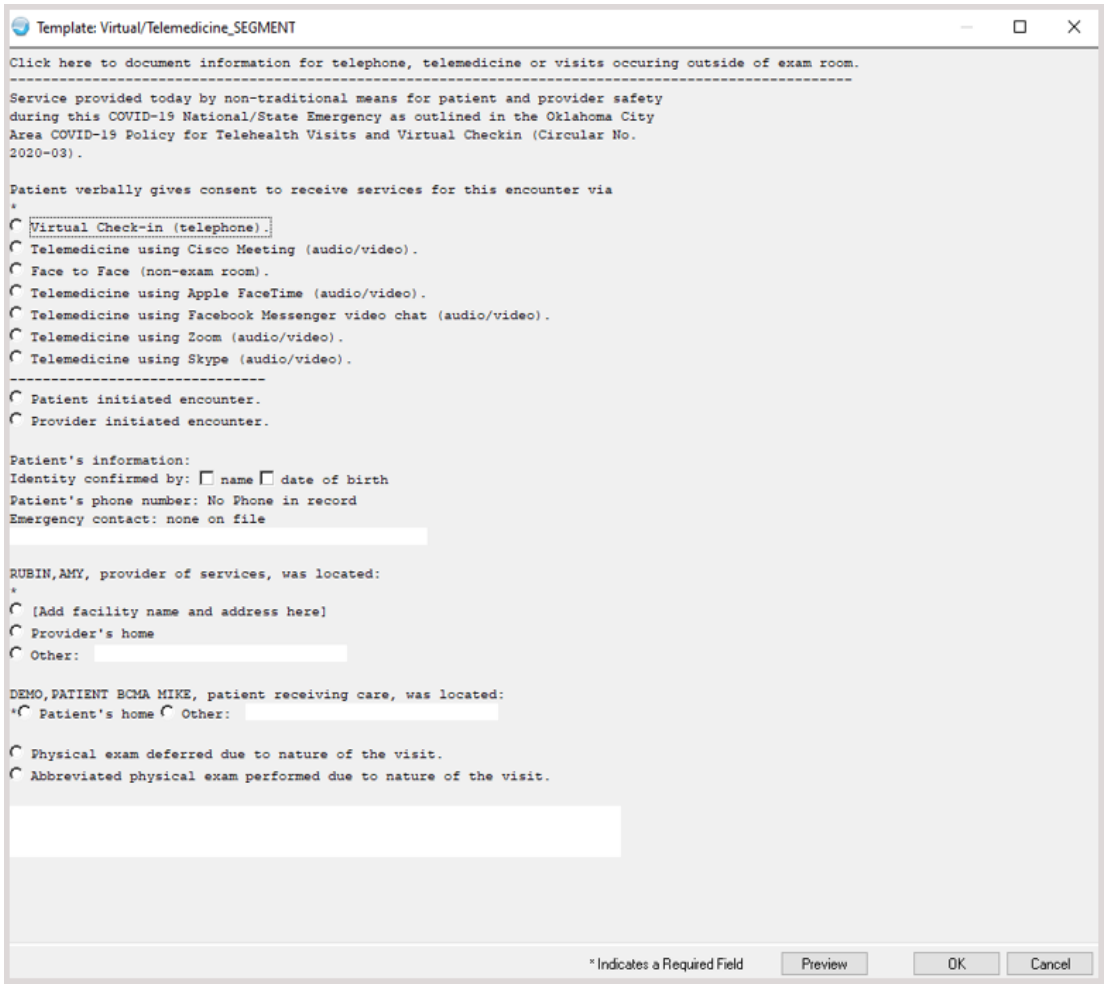

Figure 9-1: Virtual Check-in/Telemedicine_SEGMENT window

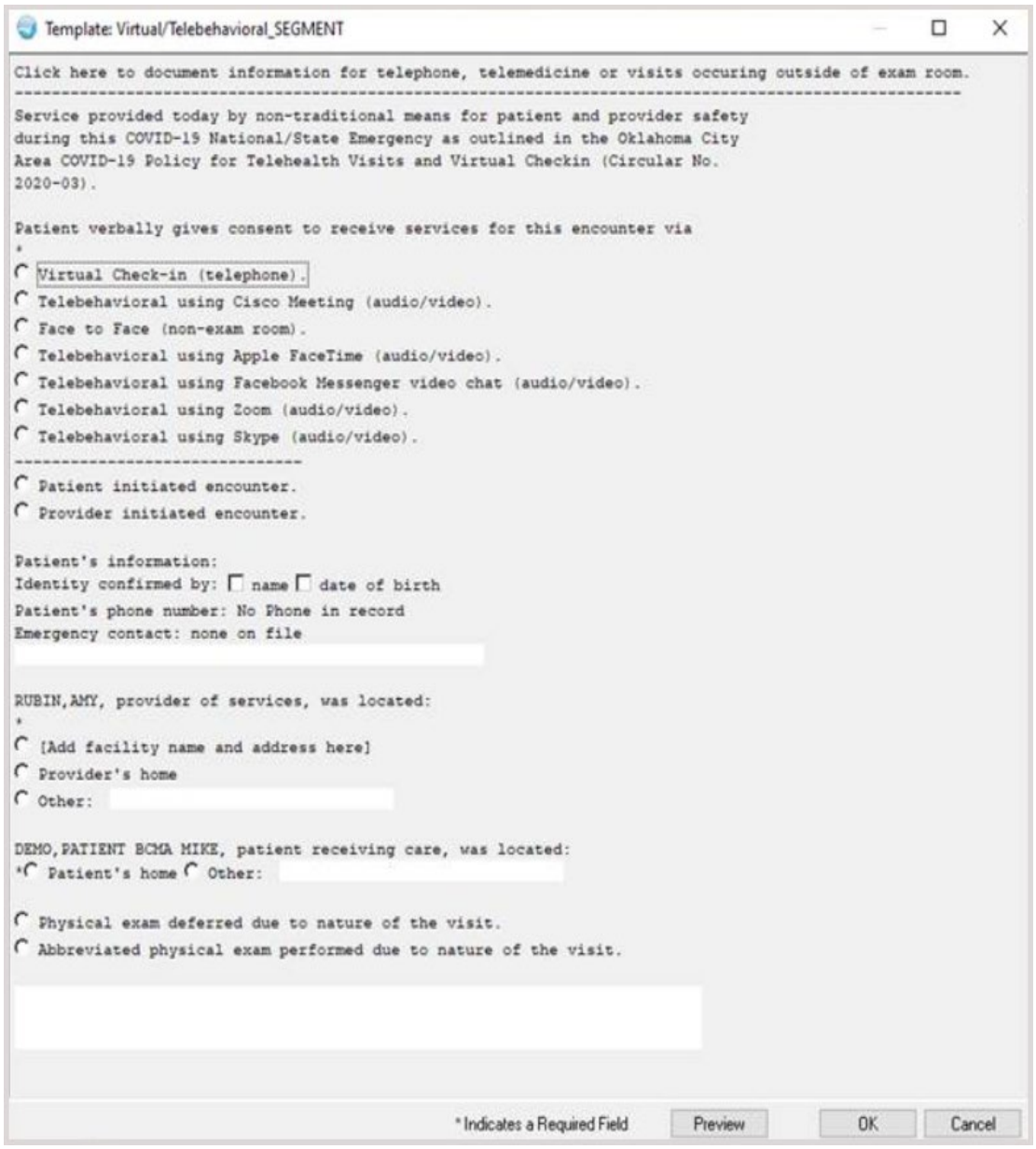

Figure 9-2: Virtual Check-In/TeleBehavioral Health window

10.0 Create EHR Quick Notes

Carefully delineate workflows to guide decisions on the use of EHR Quick Notes and when they may compliment workflows for visit creation or note title and template selection.

10.1.1 Example for Virtual Check-In and Telemedicine (Audio-Visual)

Determine how clinics will be used for scheduling. Will someone be:

- Checking patients in and out of the Practice Management Application Suite (BPRM)
- Creating a Visit encounter through the EHR New Visit tab
- Creating a Visit encounter through EHR Quick Note button (Figure 10-1)

10.1.2 Creating a Quick Note

1. Click the Quick Note icon.

Figure 10-1: Quick Note button

2. Click Create.

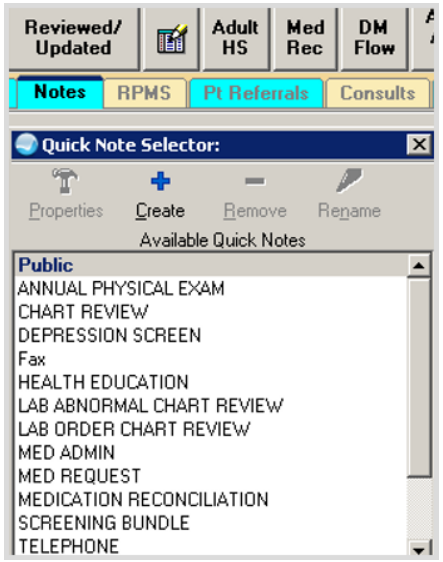

Figure 10-2: Quick Note Selector

3. Type the new **Quick Note name**.

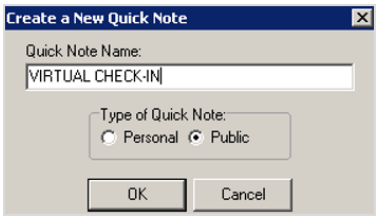

Figure 10-3: New Quick Note name on the Create a New Quick Note dialog

4. Select a Quick Note title.

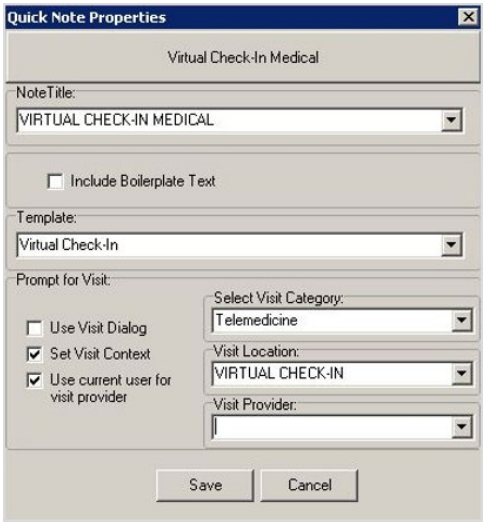

Figure 10-4: Quick Note Properties dialog

a. If checking-in patients through the Practice Management Application Suite with Create Visit at Check-in selected within Clinic configuration, setup EHR Quick Note configuration with Use Visit Dialog instead of Set Visit Context option.

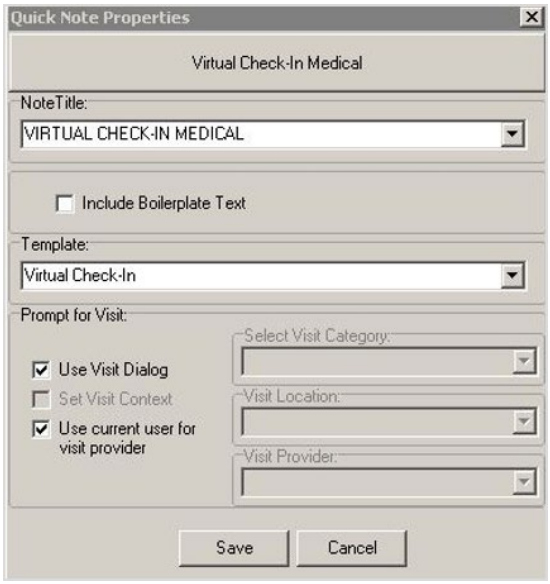

Figure 10-5: Quick Notes Properties with Use Visit Dialog selected

5. At the Quick Note Selector dialog, select VIRTUAL CHECK-IN.

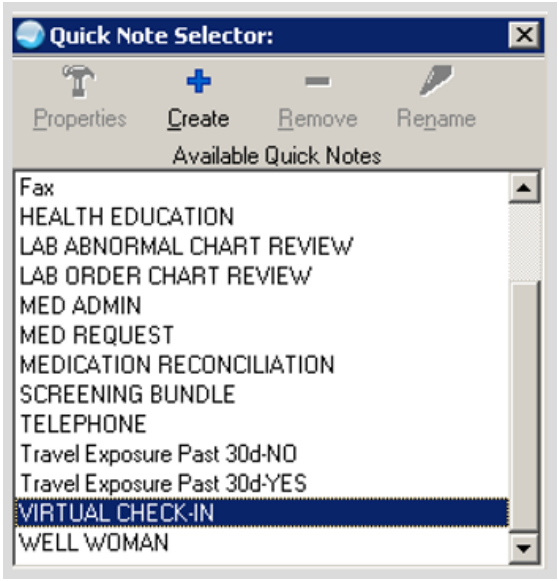

Figure 10-6: Quick Note Selector dialog

6. Type **Virtual E-Visit** on the Create a New Quick Note dialog.

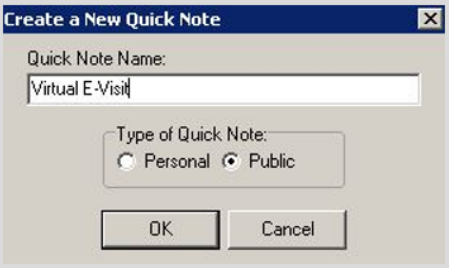

Figure 10-7: New Quick Note name on the Create a New Quick Note dialog

7. Select the Note Title E-VISIT on the Quick Note Properties dialog.

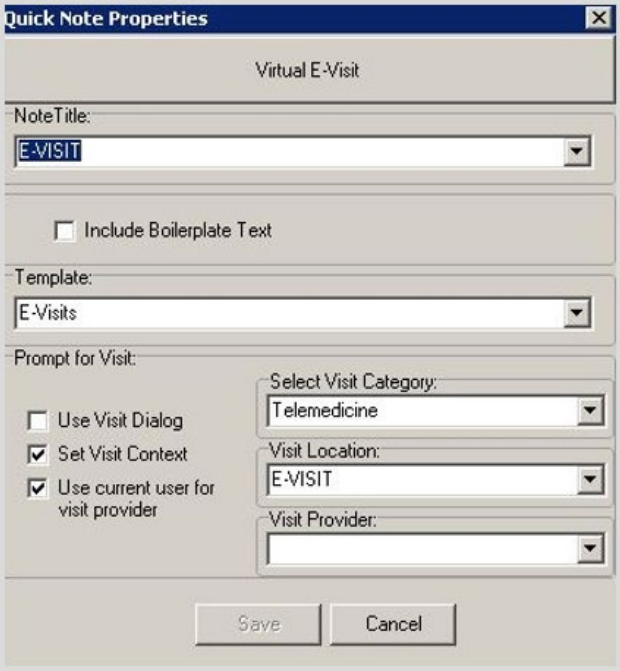

Figure 10-8: Note Title: on Quick Note Properties dialog

E-Visits will not be checked in through Practice Management Application Suite; therefore, Set Visit Context is used for this EHR Quick Note setup.

8. Continue with EHR Quick Note creation for Telemedicine, BH Virtual Check-In, TeleBehavioralHealth, and BH E-Visits as applicable for each site with similar configurations depending on check-in workflow.

   a. Use Visit Dialog with Practice Management Application Suite Check-In process to Create Visit at Check-In.

   b. Use Visit Dialog for telemedicine encounters created with EHR New Visit tab.

   c. Use Set Visit Context when Visit is created utilizing the EHR Quick Note button.

11.0 Develop/Import Pick Lists

11.1 Develop/Import Patient Education Pick Lists

Available from Toolkit.

1. Import Patient Education Pick Lists

   - ☐ **Communicable Disease**
   - ☐ **Influenza**

Example Patient Education Pick List documentation after import.

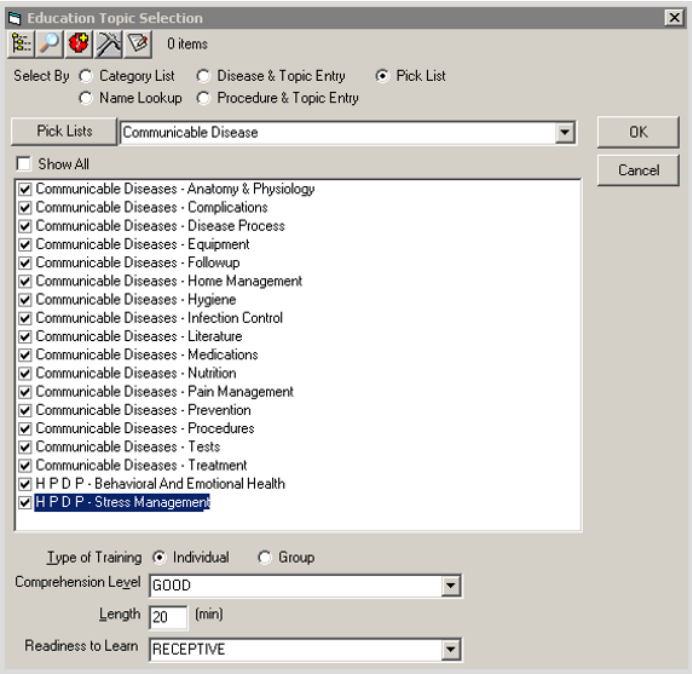

Figure 10-1: Education Topic Selection dialog with all Communicable Disease Pick List items checked, length of time defined, and comprehension level/readiness to learn options selected

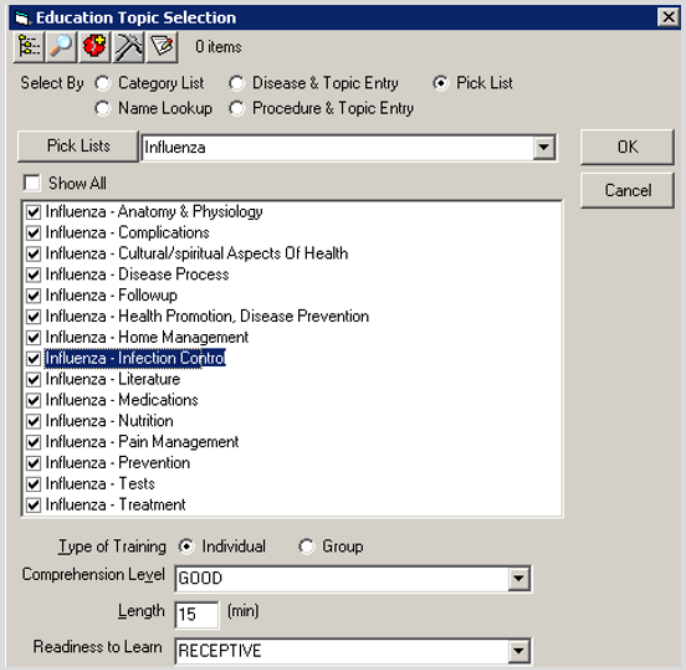

Figure 10-2: Influenza Pick List Education Topic Selection dialog

11.2 Develop/Import EHR Problem Management – Integrated Problem List – SNOMED Picklist

Available from toolkit.

1. Import COVID-19 SNOMED Picklist

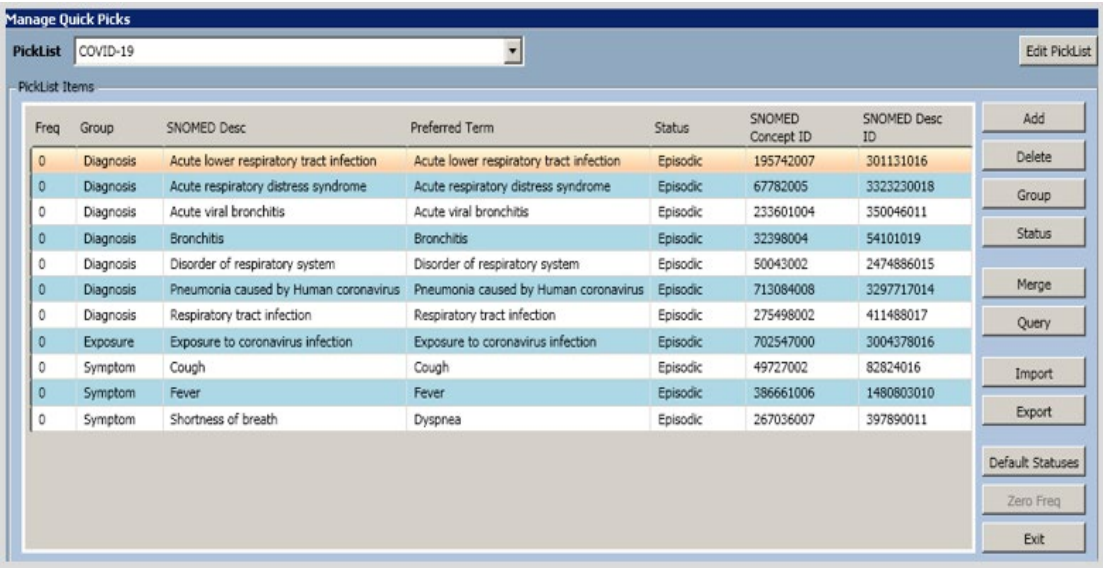

Figure 10-3: Imported COVID-19 SNOMED Picklist with Group and Status defined

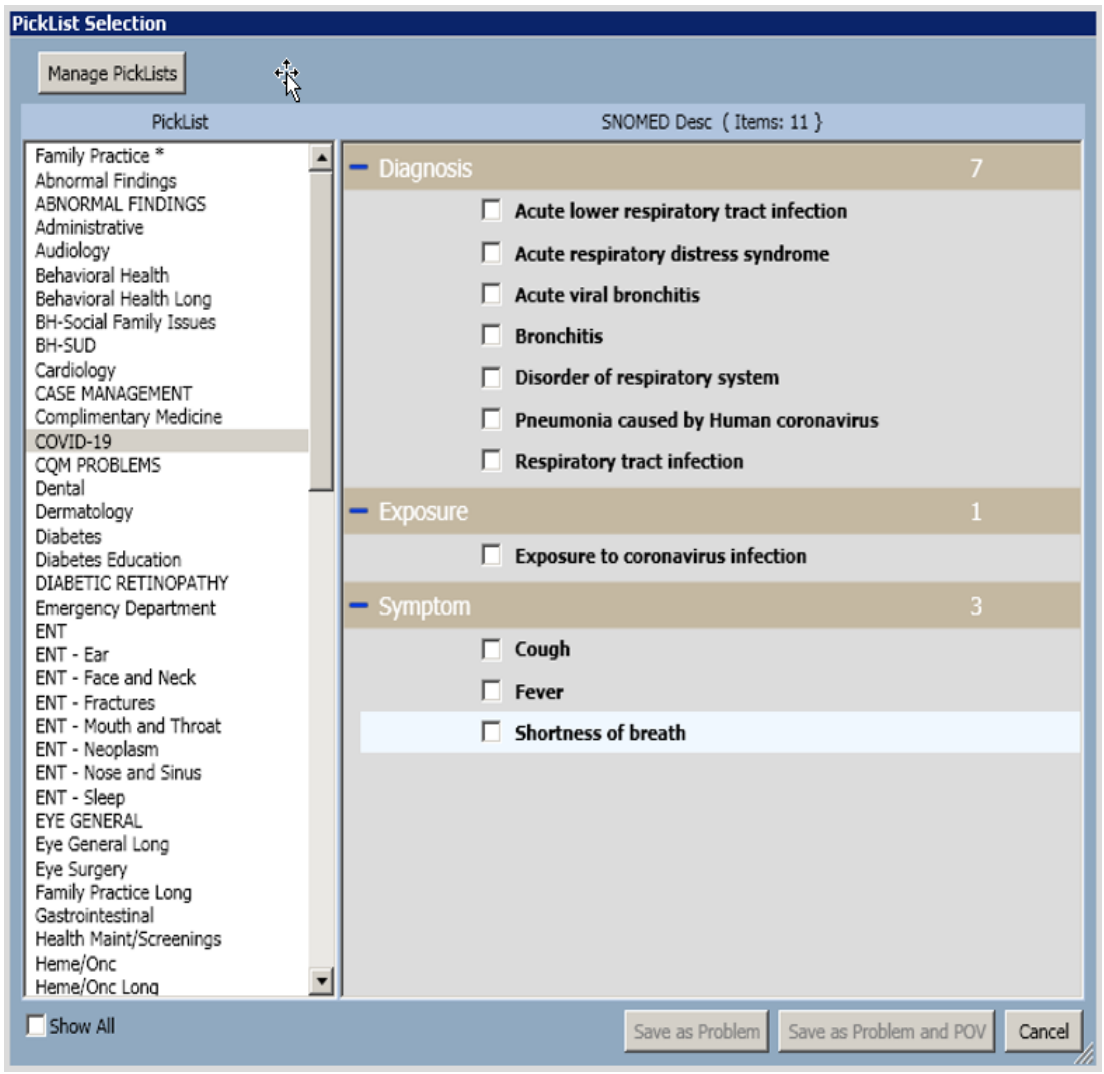

Figure 10-4: Example Provider View of imported COVID-19 SNOMED Picklist

11.3 Imported CPT Picklists Available in Toolkit

Available to import from toolkit folders.

- It is recommended that you consult with HIM (Health Information Management)/Coding/Billing staff to determine/identify/address appropriate codes, modifiers, and other associations.
- Consider clinic workflow and CMS or state-specific documentation guidance.
- Refer to the excel spreadsheet within toolkit Superbill CPT Picklist folder for possible associations and expanded narratives. Associations may include CPT modifiers as applicable for the type of service and CMS/state-specific documentation guidance.

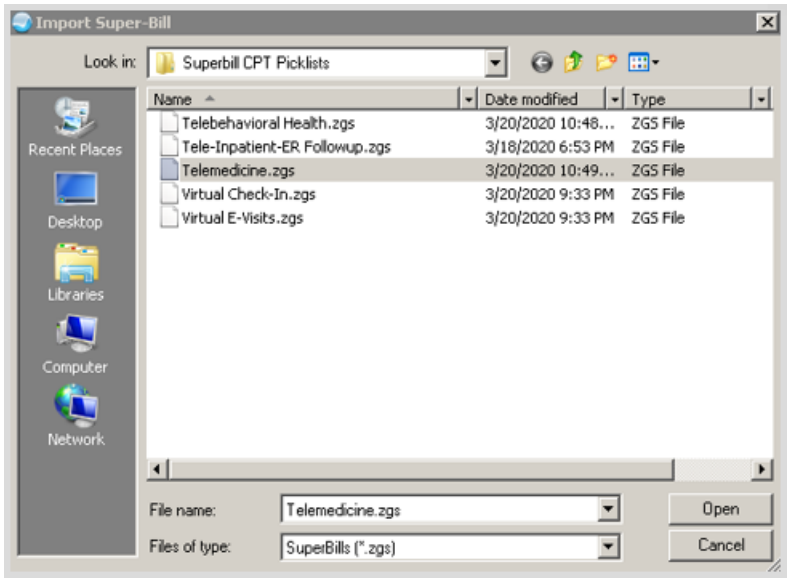

Figure 11-5: Import Super-Bill dialog

> **Note:** Associations can be added to facilitate documentation of modifiers, patient education codes, etc.

Associations and modified narratives are not imported with CPT picklists. Carefully review and reference state-specific documentation requirements and utilize the excel spreadsheet to plan out which modifiers or other associations will be used.

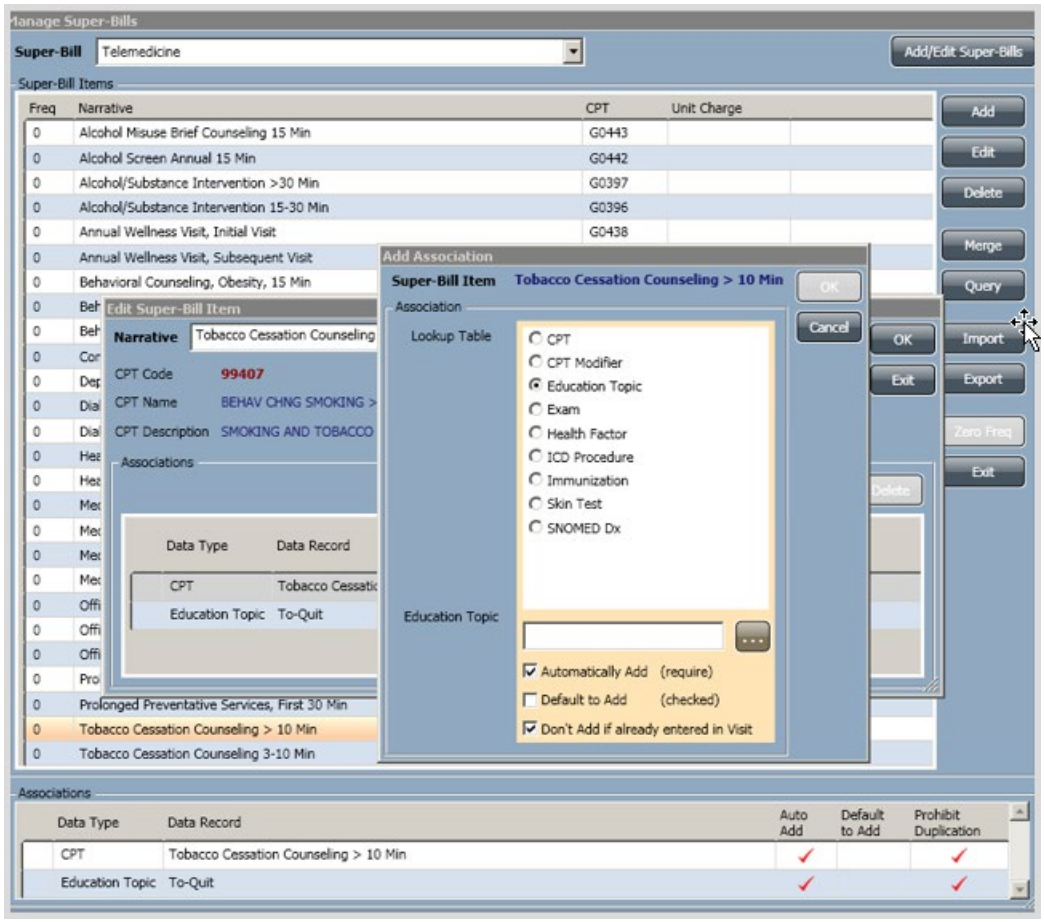

Figure 11-6: Add Association to Super-Bill Item dialog

11.3.1 Telemedicine

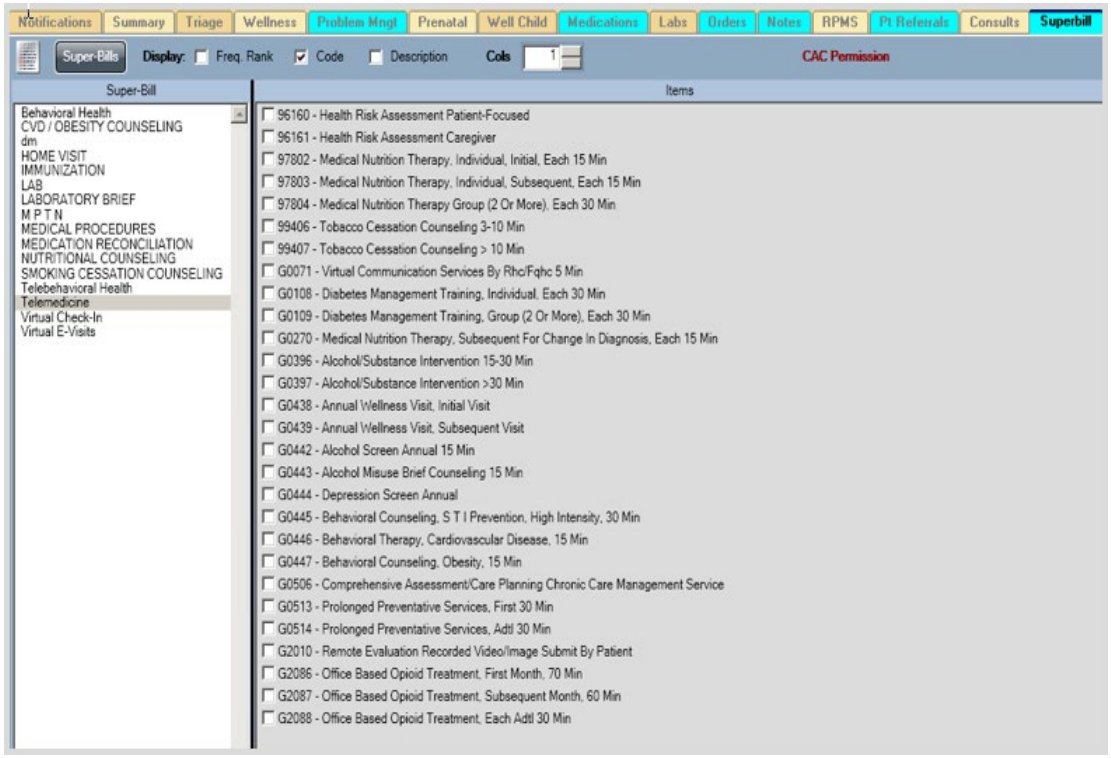

Figure 11-7: Telemedicine Superbill window

11.3.2 Virtual Check-In

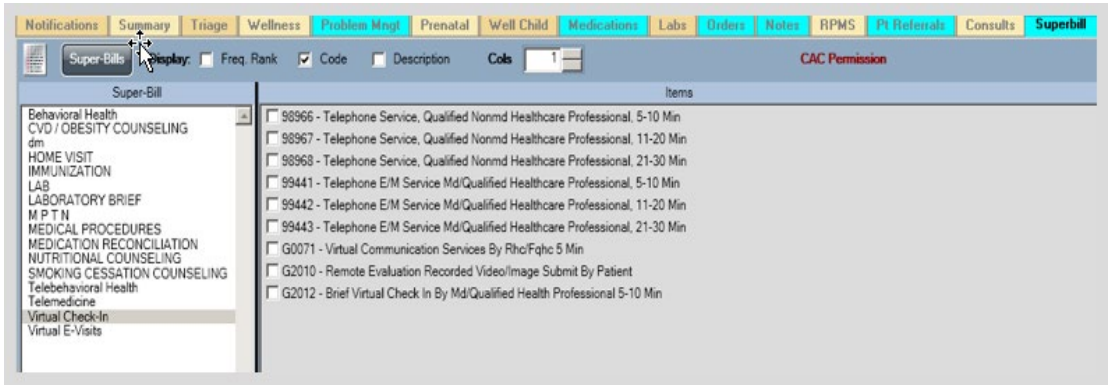

Figure 11-8: Virtual Check-In window

11.3.3 Virtual E-Visits

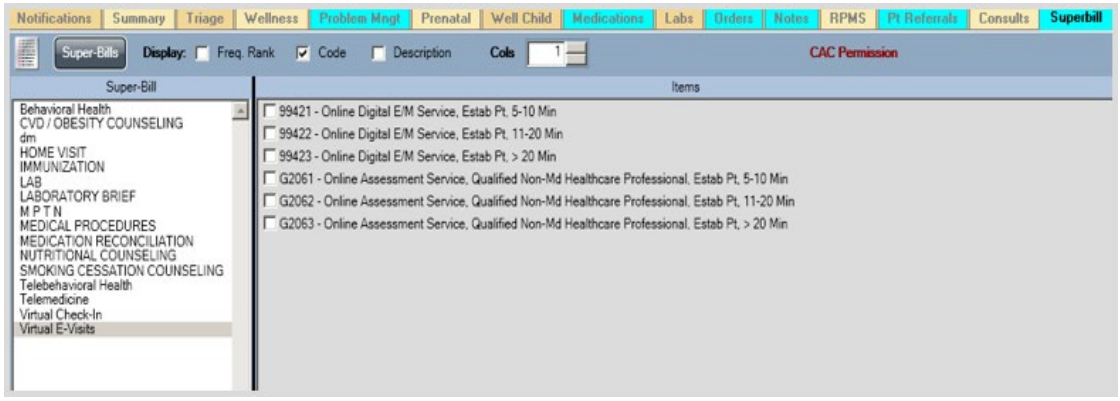

Figure 11-9: Virtual E-Visits window

11.3.4 TeleBehavioral Health

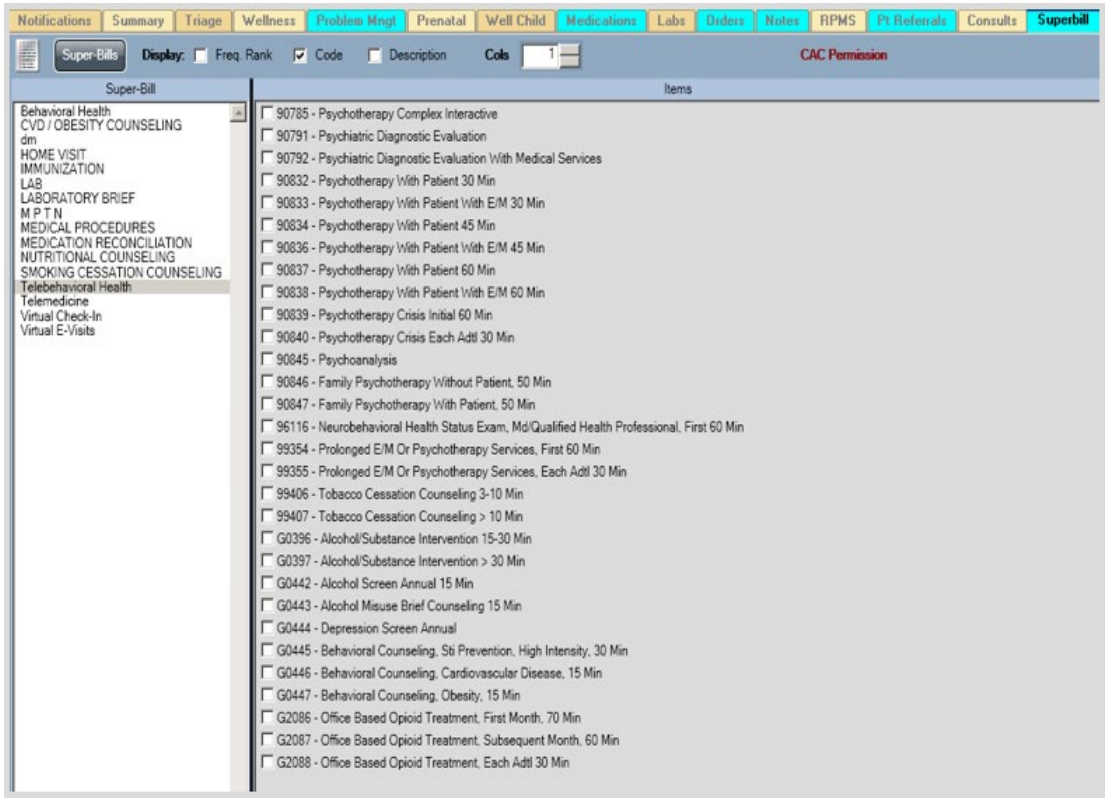

Figure 11-10: Telebehavioral Health window

11.3.5 Tele-Inpatient/ER Follow-Up

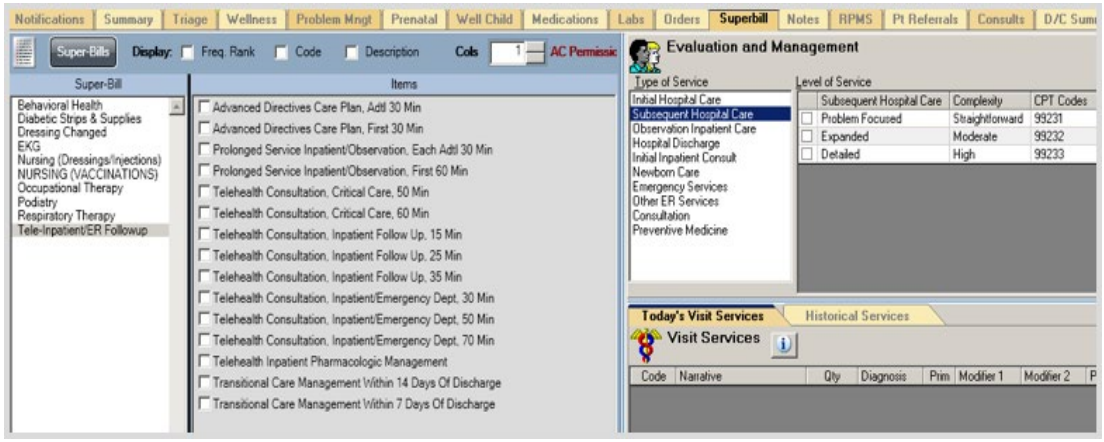

Figure 11-11: Tele-Inpatient/ER Follow-Up

If you are unsure of how to do any of the steps outlined in this guide, contact your Area support team or join OIT EHR Office Hours for assistance.

12.0 Billing Code Updates

As a result of the need for COVID-19 reporting, several code sets have been updated that affect billing. These updates will be released in RPMS patches that update the CPT (RPMS Namespace ACPT) and ICD (RPMS Namespace AUM) code sets.

12.1 CPT Code

Due to the emergent nature of the public health concern surrounding novel coronavirus testing, the American Medical Association (AMA) Current Procedural Terminology (CPT®) Editorial Panel convened a special meeting and approved a new, specific CPT code to describe laboratory testing for severe acute respiratory syndrome corona-virus 2 (SARS-CoV-2).

> **Note:** Per the World Health Organization, the official name of the virus is severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), while the name of the disease it causes is coronavirus disease (COVID-19).

The AMA expedited the publication of this new CPT code to the AMA Web site on Friday, March 13, 2020:

https://www.ama-assn.org/practice-management/cpt/cpt-releases-new-coronavirus-covid-19-code-description-testing

This code is effective immediately for use in reporting this testing service. Be aware that code 87635 is not in the CPT 2020 publication; however, it will be included in the CPT 2021 code set in the Microbiology subsection of the Pathology and Laboratory section.

- **CPT Code 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.

Download the CPT Assistant for additional information located on the AMA Web site:

https://www.ama-assn.org/practice-management/cpt/cpt-releases-new-coronavirus-covid-19-code-description-testing

12.2 HCPCS Billing Codes

The CMS has authorized the release of two new Healthcare Common Procedure Coding System (HCPCS) codes to use for billing when administering COVID-19 tests. HCPCS is a standardized coding system that Medicare and other health insurers use to submit claims for services provided to patients. Two HCPCS billing codes to be used for testing and tracking new cases of both the SARS-CoV-2 and SARS-CoV-2/2019-nCoV (COVID-19) viruses are listed.

- **HCPCS billing code (U0001)**

  In March 2020 the CMS developed the first HCPCS billing code (U0001) for tests and tracking new cases of the SARS-CoV-2 virus. This code is used specifically for CDC testing laboratories that are testing patients.

- **HCPCS billing code (U0002)**

  The second HCPCS billing code (U0002) released allows laboratories to bill for non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19).

  On February 29, 2020, the Food and Drug Administration (FDA) issued a new, streamlined policy for certain laboratories to develop their own validated COVID-19 diagnostics. The second HCPCS code (U0002) may be used for tests developed by these additional laboratories when submitting claims to Medicare or health insurers. CMS expects that having specific codes for these tests will encourage testing and improve tracking.

The following two codes are effective March 1, 2020:

- **HCPCS Billing code (G2023)**

  Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source.

- **HCPCS Billing Code (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.

12.3 ICD-10 Diagnosis Coding

- **ICD-10 Diagnosis Code U07.1**

  On January 30, 2020, the World Health Organization (WHO) declared the 2019 Novel Coronavirus (2019-nCoV) disease outbreak a public health emergency of international concern.

As a result of the declaration, the WHO Family of International Classifications (WHOFIC) Network Classification and Statistics Advisory Committee (CSAC) convened an emergency meeting on January 31, 2020 to discuss the creation of a specific code for this new coronavirus. A new International Classification of Diseases, Tenth Revision (ICD-10) emergency code (U07.1, 2019-nCoV acute respiratory disease) has been established by WHO.

ICD-10-CM interim coding guidance can be found at:

https://www.cdc.gov/nchs/icd/icd10cm.htm

12.4 Clinic Stop Codes

- **Public Health Emergency (E8)**

  A clinic that provides health services in response to a public health emergency at the national, regional, or local level. Such as, but not limited to, epidemic, pandemic or natural disasters.

13.0 IHS Response Including the Office of Information Technology (OIT)

Going forward, the OIT will be releasing updates to RPMS to allow for data capture of COVID-19 testing and reporting. The following summaries are planned:

- ACPT 2.20 Patch 1 – Releases the new CPT and HCPCS codes
- AUM Version 2020 Patch 2 – Updates the ICD Diagnosis file and a new Clinic Stop code
- ATX 5.1 Patch 33 – Adds seven new diagnosis codes along with mapping to taxonomy codes
- DTS Cycle 40
- Laboratory (LR) 5.2 Patch 1043 and Patch 1044
- PCC and EHR – No updates have been identified at this time
- Third Party Billing – No updates are needed at this time

OIT will also be publishing guidance for use of the new lab testing and billing codes within the RPMS suite of applications.

14.0 CMS Guidance

To keep up with the important work CMS is doing in response to COVID-19, visit the Current Emergencies Web site.

Summary of CMS Public Health Action on COVID-19 to date:

- On March 9, 2020: CMS delivered guidance on the screening, treatment and transfer procedures healthcare workers must follow when interacting with patients to prevent the spread of COVID-19 in a hospice setting. CMS also issued additional guidance specific to nursing homes to help control and prevent the spread of the virus.

  https://www.cms.gov/newsroom/press-releases/cms-issues-clear-actionable-guidance-providers-about-covid-19-virus

- On March 9, 2020: CMS issued a press release highlighting the telehealth benefits in the agency's Medicare program for use by patients and providers. Expanded use of virtual care, such as virtual check-ins, are important tools for keeping beneficiaries healthy, while helping to contain the community spread of the COVID-19 virus.

  https://www.cms.gov/newsroom/press-releases/telehealth-benefits-medicare-are-lifeline-patients-during-coronavirus-outbreak

- On March 9, 2020: CMS published guidance to hospitals with emergency departments (EDs) on patient screening, treatment and transfer requirements to prevent the spread of infectious disease and illness, including COVID-19. Medicare-participating hospitals are to follow both CDC guidance for infection control and Emergency Medical Treatment and Labor Act (EMTALA) requirements.

  https://www.cms.gov/newsroom/press-releases/cms-issues-call-action-hospital-emergency-departments-screen-patients-coronavirus

  March 6, 2020: CMS issued frequently asked questions and answers (FAQs) for healthcare providers regarding Medicare payment for laboratory test and other services related to the 2019-Novel Coronavirus (COVID-19).

  https://www.cms.gov/newsroom/press-releases/covid-19-response-news-alert-cms-issues-frequently-asked-questions-assist-medicare-providers

- March 5, 2020: CMS issued a second Healthcare Common Procedure Coding System (HCPCS) code for certain COVID-19 laboratory tests, in addition to three fact sheets about coverage and benefits for medical services related to COVID-19 for CMS programs.

https://www.cms.gov/newsroom/press-releases/cms-develops-additional-code-coronavirus-lab-tests

March 4, 2020: CMS issued a call to action to healthcare providers nationwide and offered important guidance to help State Survey Agencies and Accrediting Organizations prioritize their inspections of healthcare.

https://www.cms.gov/newsroom/press-releases/cms-announces-actions-address-spread-coronavirus

- February 13, 2020: CMS issued a new HCPCS code for providers and laboratories to test patients for COVID-9.

  https://www.cms.gov/newsroom/press-releases/public-health-news-alert-cms-develops-new-code-coronavirus-lab-test

- February 6, 2020: CMS gave CLIA-certified laboratories information about how they can test for SARS-CoV-2.

  https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/notification-surveyors-authorization-emergency-use-cdc-2019-novel-coronavirus-2019-ncov-real-time-rt

- February 6, 2020: CMS issued a memo to help the nation's healthcare facilities take critical steps to prepare for COVID-19.

  https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/information-healthcare-facilities-concerning-2019-novel-coronavirus-illness-2019-ncov

Sites are encouraged to check with their Medicare Administrative Contractor (MAC) for billing updates.

14.1 RPMS Billing Set up

Telemedicine visits will use the M-Telemedicine Service Category so no set up by Service Category is needed in Third Party Billing. There are some parameters that should be checked to ensure that all services will generate a claim. Work with your coding staff to determine which clinic codes will be used for Telemedicine and Telehealth services. The clinic stop codes must be noted when reviewing parameters.

14.1.1 Site Parameters

(3PB→TMTP→SITM)

A review of certain prompts in Site Parameters must be completed to ensure that the correct unbillable clinics and providers are listed. It is assumed that these entries were added at the initial implementation of the Third-Party Billing package and are usually reviewed annually but performing a review would be recommended.

Site Parameters for each billable location must be reviewed if Telemedicine services are to be performed at those locations. Make sure that Telemedicine Clinic is not listed. This means reviewing satellite locations as well as HOME, PHN LOCATION, and OTHER visit locations.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |        THIRD PARTY BILLING SYSTEM - VER 2.6p26          |
          +               Site Parameter Maintenance                +
          |                 INDIAN HEALTH HOSPITAL                  |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: LUJAN,ADRIAN M                    25-MAR-2020 10:07 AM

EMC File Preference.............:
DEFAULT EMC PATH................:
Facility to Receive Payments....:
Printable Name of Payment Site..:
Current Default Fee Schedule....:
Create Bills for all Patients...:
Always Display Beneficiary Patient:
Require that Queing be Forced...:
Display Long ICD/CPT Description:
Backbilling Limit (months)......:
Block 31 (HCFA 1500) print......:
UB-92 SIGNATURE.................:
Place of Service Code...........:
Bill Number Suffix (fac-code)...:
Append HRN to Bill Number.......:
Allow for CPT Modifiers Prompt..:
Set Prof. Comp. Automatically...:
Default Version of HCFA-1500....:
Default Form for Dental Billing.:
VA STATION NUMBER:
VA CONTRACT NUMBER:
Select DEFAULT UNBILLABLE CLINICS:
Select DFLT INVALID PRV DISCIPLINES:
Select DISPLAY UNBILLABLE INSURER(S):
UB-92 Form Locater 38: INSURER ADDRESS//
IN-HOUSE DEFAULT CLIA#:
REFERENCE LAB DEFAULT CLIA#:
ORPHAN VISIT LAG TIME (DAYS)....:
UNCODED DX LAG TIME (DAYS):
```

Figure 14-1: Display of the Unbillable Clinics and Unbillable Provider Disciplines in Site Parameters

14.1.1.1 Select Default Unbillable Clinics Option

This option is used to identify clinic codes that may not be billable **for the visit location** the user is setting up. For example, if the facility has a Clinic Stop code that coding uses to identify unbillable services such as Telephone Call (51), that code may be listed as an unbillable clinic. Type a single question mark (**?**) to view all entries.

```
Select DEFAULT UNBILLABLE CLINICS: ?
    Answer with DEFAULT UNBILLABLE CLINICS
   Choose from:
   TELEPHONE CALL
   CHART REV/REC MOD
   EMPLOYEE HEALTH UNIT


     You may enter a new DEFAULT UNBILLABLE CLINICS, if you wish
 Answer with CLINIC STOP NAME
 Do you want the entire 141-Entry CLINIC STOP List?
```

Figure 14-2: Display of the Unbillable Clinics Entry in Site Parameters

If coding determines that TELEPHONE CALL will now be a billable clinic code, the entry must be deleted. To delete:

1. Type the **clinic stop code** and press Enter. The system requires confirmation of the entry.
2. Type **Yes** to confirm and press Enter.
3. Type **@** (Shift+2) at the 'Select DEFAULT UNBILLABLE CLINICS' prompt to delete the entry.

```
Select DEFAULT UNBILLABLE CLINICS: TELEPHONE CALL       51
         ...OK? Yes//   (Yes)

DEFAULT UNBILLABLE CLINICS: TELEPHONE CALL// @
   SURE YOU WANT TO DELETE THE ENTIRE DEFAULT UNBILLABLE CLINICS? YES
```

Figure 14-3: Deleting an Unbillable Clinics Entry

Once deleted, you may type a single question mark (**?**) at the prompt to view all unbillable entries.

> **Note**: Once the entry is deleted, all visits the Claim Generator reviews from that date forward with the deleted clinic stop code will be considered when generating a claim. The system does not generate claims for past visits unless a Backbilling Check is performed (3PB→MGTP→BKMG). **Do not perform a Backbilling Check at this time.**

14.1.1.2 Select Default Unbillable Provider Disciplines Option

This option is used to identify provider discipline codes that may not be billable **for the visit location** the user is setting up. For example, if the Laboratory Technician has been designated as Unbillable, the entry may be added. Once a provider discipline code has been added, the system never generates a claim for this provider type, where the provider is listed as the primary provider on the visit. Type a single question mark (**?**) to view all entries and note the entries that may be billable. Check with coding to confirm entries.

```
Select DFLT INVALID PRV DISCIPLINES: ?
    Answer with DFLT INVALID PRV DISCIPLINES
   Choose from:
   CLINIC RN
   ADMINISTRATIVE
   CODING/DATA ENTRY


     You may enter a new DFLT INVALID PRV DISCIPLINES, if you wish
 Answer with PROVIDER CLASS NAME
 Do you want the entire 146-Entry PROVIDER CLASS List?
```

Figure 14-4: Display of the Unbillable Provider Disciplines Entries

If coding determines that the provider discipline is now a billable provider, the entry must be deleted. To delete:

1. Type the **clinic stop code** and press Enter. The system requires confirmation of the entry.
2. Type **Yes** to confirm and press Enter.
3. Type **@** (Shift+2) at the Select DEFAULT UNBILLABLE CLINICS prompt to delete the entry.

```
Select DFLT INVALID PRV DISCIPLINES: CLINIC RN
         ...OK? Yes// <enter>  (Yes)

DFLT INVALID PRV DISCIPLINES: CLINIC RN// @
   SURE YOU WANT TO DELETE THE ENTIRE DFLT INVALID PRV DISCIPLINES? YES
```

Figure 14-5: Deleting the Unbillable Provider Disciplines Entry

Once deleted, you may type a single question mark (**?**) at the prompt to view all unbillable entries.

> **Note**: Once the entry is deleted, all visits the Claim Generator reviews from that date forward with the deleted provider discipline will be considered when generating a claim. The system does not generate claims for past visits unless a Backbilling Check is performed (**3PB→MGTP→BKMG**). **Do not perform a Backbilling Check at this time.**

14.1.2 Coverage Type Maintenance

(3PB→TMTP→COTM→EDCO)

This option allows the user to set up Insurers by the types of coverage the payer offers. The most common example for Third Party Billing is set for Medicare Part A and Medicare Part B where *Medicare* is the insurer and *Part B* is the Coverage Type. Other payers, such as the State Medicaid plans, may have been set up at one point in time. Coverage Types may be set up to make a clinic stop code, diagnosis or provider discipline unbillable.

Coverage Types may need to be reviewed to ensure that services that were not covered prior to the COVID-19 billing expansion will generate claims. To review,

1. Type the **name of the Insurer** at the Select Insurer prompt and press Enter.
2. Type the **coverage type entry** at the Select COVERAGE TYPE to Edit field and press Enter.

```
Select INSURER: MEDICARE

Select COVERAGE TYPE to Edit: PART B          MEDICARE     B     SELF
```

Figure 14-6:Selecting the Insurer and Coverage Type Entry

3. The system displays the Plan Type. Press Enter to bypass this entry. At the Select UNBILLABLE CLINICS prompt, type a single question mark (**?**) and press Enter. Review the list of entries. If an entry needs to be deleted, use the **@** sign or Shift+2 to delete.
4. Press Enter past the Unbillable Diagnosis prompt. Review the entries and add or review as needed.

```
PLAN TYPE: SELF//
Select CLINICS UNBILLABLE: THIRD PARTY DENTAL// ?
    Answer with CLINICS UNBILLABLE
   Choose from:
   DENTAL
   EDUCATION CLASSES
   PHARMACY
   THIRD PARTY DENTAL

        You may enter a new CLINICS UNBILLABLE, if you wish
```

```
 Answer with CLINIC STOP NAME, or CODE
 Do you want the entire 141-Entry CLINIC STOP List? N  (No)
Select CLINICS UNBILLABLE: THIRD PARTY DENTAL//
Select UNBILLABLE DIAGNOSIS: .9999//
```

Figure 14-7:Display of Unbillable Clinics for the Coverage Type

5. The system will display the Select PROV CLASS (UN)BILLABLE and press Enter. Type a single question mark (**?**) to display the unbillable entries. Review the list and remove any entries that are not valid. Use the **@** sign or Shift+2 to delete entries.

```
Select PROV CLASS (UN)BILLABLE: PODIATRIST// ?
 Answer with PROV CLASS (UN)BILLABLE
 Do you want the entire 44-Entry PROV CLASS (UN)BILLABLE List? YES  (Yes)
   Choose from:
   ADMINISTRATIVE
   ALCOHOLISM/SUB ABUSE COUNSELOR
   AUDIOMETRIC TECHNICIAN
   CARDIOLOGIST
   CODING/DATA ENTRY
   COMMUNITY HEALTH REP
   CONTRACT PSYCHIATRIST
   CONTRACT PSYCHOLOGIST
   CONTRACT PUBLIC HEALTH NURSE
   CRNA
   DENTAL HYGIENIST
   DENTIST
   DIETETIC TECHNICIAN
   DIETITIAN
   DISEASE CONTROL PROGRAM
   EMT/PARAMEDIC
   ENVIRONMENTAL HEALTH
   FAMILY PLANNING COUNSELOR
   FOOD SERVICE SUPERVISOR
   HEALTH AIDE
   HEALTH EDUCATOR
   HEALTH RECORDS
   LABORATORY TECHNICIAN
   LICENSED PRACTICAL NURSE
   MEDICAL SOCIAL WORKER
   MEDICAL STUDENT
   MENTAL HEALTH TECHNICIAN
   NURSE ASSISTANT
   NURSE MIDWIFE
   NUTRITION TECHNICIAN
   NUTRITIONIST
   OPTOMETRIC ASSISTANT
   OTHER
   OUTREACH WORKER
   PAPAGO NUTRITION PROGRAM
   PHARMACIST
   PHARMACY PRACTITIONERS
   PODIATRIST
   PSYCHOLOGIST
   PUBLIC HEALTH NURSE
   SCHOOL NURSE
   STUDENT NURSES
```

```
  TRIBAL/CONTRACT NUTRITIONIST
  XRAY TECHNICIAN

       You may enter a new PROV CLASS (UN)BILLABLE, if you wish

Answer with PROVIDER CLASS NAME, or ABBREV. TITLE, or CODE
Do you want the entire 146-Entry PROVIDER CLASS List?
```

Figure 14-8:Display of Unbillable Provider Disciplines

14.1.3 The Insurer File

No new insurer entries will need to be added at this time but if needed, add any new visit types to be billed.

14.1.3.1 Visit Types

If new Visit types have been added to the billing package for use when approving claims, add it to the visit type section of the insurer file.

Remember, the Clinic Stop code may be linked to the Visit Type. If the linked visit type is added in to the insurer file, the claims that generate will create with the visit type the clinic was linked to.

For example, a new Visit Type titled 'DRIVE THROUGH CLINIC' may be added. This visit type may be used with the E8 Clinic Stop Code in addition to the location used from EHR. In this case, the Place of service Code may be added using a form locator override.

14.1.4 Place of Service Codes (POS)

Place of Service (POS) codes are used to indicate where the services were performed and are seen on the CMS-1500 paper form or the 837 Professional claim forms and is used to report services for the attending provider. In Third-Party Billing, the Place of Service code is defaulted by visit location.

14.1.4.1 Site Parameters

The default Place of Service code is stored in Site Parameters for each billing location. The default may be checked but no changes should be made for this prompt.

```
Block 31 (HCFA 1500) print......:
UB-92 SIGNATURE.................:
Place of Service Code...........: 22//     ←Review entry
Bill Number Suffix (fac-code)...:
Append HRN to Bill Number.......:
```

Figure 14-9; Viewing the Place of Service Code in Site Parameters

14.1.4.2 Form Locator Override

If certain services require a Place of Service code different than the code listed in Site Parameters, an override may be added to send the required code. This is set by Insurer and can also be set by Visit Type. For example, if the Telemedicine Place of Service code is needed to bill for the Distant or provider's services for New Mexico Medicaid, the user would set up Form Locator Override by:

1. In Table Maintenance, select Form Locator Override.
2. At the Select Insurer Name field, type the **name** of the insurer to override.
3. Type the **name** of the export mode to override.
4. Type **24** for the Line Item to edit
5. The system will ask for a VISIT TYPE. Type the **entry name** to override. For this example, type **TELEMEDICINE** or the **Visit Type number**.
6. The system displays the fields for Form Locator 24. Type **3** to select B-POS.
7. At the DATA VALUE field, type **02** to add the Telemedicine Place of service code. Be sure to verify that the correct entry has been added, as the Form Locator Override does not validate the entry that was added.

```
Select INSURER NAME: NEW MEXICO MEDICAID     NEW MEXICO     87125-6500
         ...OK? Yes//

Select 3P EXPORT MODE FORMAT: CMS-1500 (02/12)       OMB No. 0938-1197

     Select one of the following:

          1         PAYER TYPE
          10        RESERVED FOR LOCAL USE
          11        BOX 11C - INSURANCE PLAN/PROGRAM NAME
          19        RESERVED FOR LOCAL USE
          24        LINE ITEMS
          241       LINE 24, LINE 1 ITEM
          31        SIGNATURE OF PHYSICIAN
          32        WHERE SERVICES RENDERED
          33        BILLING INFO

Select Form Locator: 24  LINE ITEMS
Enter visit type, or leave blank for all. 501  TELEMEDICINE DISTANT

     Select one of the following:

          1         A1 - DOS FROM
          2         A2 - DOS TO
          3         B - POS
          4         C - EMG
          5         D - HCPCS
          6         E - DIAGNOSIS
          7         F - CHARGE
          8         G - UNITS
          9         H - EPSDT
```

```
          10        I - QUALIFIER
          11        J - PROVIDER#

Which Section?: 3  B - POS
  Are you adding 'FM35 BOX 24 3 501' as
  a new FORM LOCATOR OVERRIDE (the 4TH for this 3P INSURER)? No// YES (Yes)
DATA VALUE: 02
```

Figure 14-10: Adding a Place of Service Value to the Form Locator Override

> **Note:** To add a default value by VISIT TYPE, the entry must first exist in the 3P VISIT TYPE file.

14.2 Fee Schedules

With the addition of the new CPT and HCPCS codes, fees must be established in order to bill for these services.

It is important to understand what the reimbursement rate for each payer is to ensure that an appropriate price is added for each procedure. Remember to never use the fee schedule that Medicare publishes since that fee schedule indicates how Medicare will pay for those services.

Best practice would be to work with your Laboratory Supervisor to determine which tests are similar to each CPT/HCPCS set and then determine the price according to those similar tests. Another approach would be to work with your fee schedule vendor (provided that the fees were recently purchased) to obtain an update for the new codes.

14.2.1 Updating the Fee Schedule

Once the pricing for the new CPT/HCPCS codes has been determined, it is important to immediately update the fee schedule. Do to this, determine the following:

1. The fee schedule being currently being used.
2. Payers that are using a different fee schedule.
3. Updating the Fee Schedule.

14.2.1.1 Determine Current Fee Schedule

Fee schedules are created and stored by billing location. This means that a site may have multiple fee schedules assigned to a parent or satellite locations. Locate the billing location's fee schedule by accessing the Site Parameters.

1. Press Enter to get to the Current Default Fee Schedule to view the Default Fee Schedule. The entry listed is the default for the billing location.

2. Type one question mark (**?**) to view the description of fee schedule entries. Note the default entry.

```
EMC File Preference.............:
DEFAULT EMC PATH................:
Facility to Receive Payments....:
Printable Name of Payment Site..:
Current Default Fee Schedule....: 31// ?
     This field indicates which schedule will be used for itemized billing for
     those Insurers that do not require the use of their own fee schedule.
 Answer with 3P FEE TABLE SCHEDULE NUMBER
 Do you want the entire 17-Entry 3P FEE TABLE List? Y  (Yes)
   Choose from:
   1        IHS 1995 STANDARD FEE SCHEDULE
   2        MEDICARE O/P SURGERY
   3        NM MEDICARE 2001 FEE SCHEDULE
   4        2002 RBRVS FEE SCHEDULE
   5        2003 FEE SCHEDULE (3/26/03)
   6        2004 FEE SCHEDULE (9/10/03)
   7        MEDICAID DENTAL FEE SCHEDULE
   8        MEDICAID FLAT RATE
   9        2005 FEE TABLE (2/17/05)
   10        MEDICAID T1015 FEE
   22        2006 FEE SCHEDULE (2/17/05)
   23        2007 FEE SCHEDULE (9/12/2006)
   27        2009 INGENIX FEES (2/10/09)
   29        2011 FEE SCHEDUEL (05/14/2011)
   30        2016 FEE SCHEDULE (1/18/2016)
   31        HISTORICAL FEE SCHEDULE (3/11/2018)
   45        2009 DNTL FEE

Current Default Fee Schedule....: 31//
Create Bills for all Patients...:
```

Figure 14-11: Viewing the Site Parameters Default Fee Schedule entry

Remember to check the fee schedule entry for each billing location. The entries that you record will need to be updated with the new fees.

14.2.1.2 Payers Using a Different Fee Schedule

The Visit Type within the Insurer File allows a fee schedule to be stored. This is meant to be populated if the payer is to be billed using a fee schedule that is not part of the site's default fee schedule. It is strongly recommended to leave this field blank but to ensure that all schedules are updated accordingly, it helps to generate a report to view all fee entries by insurer.

To view what has been entered, run a FileMan report if you have access to the A/R FileMan Report option in the Manager Menu.

1. Type **ABM** at the Select Package Name prompt and press Enter.
2. Type **3P INSURER** at the Select FILE prompt and press Enter.

3. At the Sort by prompt, type **VISIT TYPE** and press Enter.
4. At the VISIT TYPE SUB FIELD prompt, type **FEE SCHEDULE** and press Enter.
5. Press Enter at the START WITH FEE SCHEDULE, SORT BY prompt. The system asks for the print criteria.
6. Type **INSURER;L25** at the FIRST PRINT FIELD prompt and press Enter.
7. At the THEN PRINT FIELD, type **VISIT TYPE** and press Enter.
8. At the THEN PRINT VISIT TYPE SUB-FIELD, type **VISIT TYPE;L15** and press Enter.
9. At the next THEN PRINT VISIT TYPE SUB-FIELD, type **BILLABLE STATUS'L6** and press Enter.
10. At the next THEN PRINT VISIT TYPE SUB-FIELD, type **FEE SCHEDULE;L5** and press Enter.
11. Press Enter at the next THEN PRINT VISIT TYPE SUB-FIELD.
12. press Enter at the THEN PRINT FIELD prompt.
13. At the DEVICE prompt, select a printer or print to the screen.

```
Select PACKAGE NAME: ABM   IHS 3P BILLING SYSTEM
Select FILE: 3P INSURER
SORT BY: NUMBER// VISIT TYPE    (multiple)
VISIT TYPE SUB-FIELD: FEE SCHEDULE
START WITH FEE SCHEDULE: FIRST// <enter>
  WITHIN FEE SCHEDULE, SORT BY: <enter>
FIRST PRINT FIELD: INSURER;L25
THEN PRINT FIELD: VISIT TYPE    (multiple)
  THEN PRINT VISIT TYPE SUB-FIELD: VISIT TYPE;L15
  THEN PRINT VISIT TYPE SUB-FIELD: BILLABLE STATUS;L6
  THEN PRINT VISIT TYPE SUB-FIELD: FEE SCHEDULE;L5
  THEN PRINT VISIT TYPE SUB-FIELD: <enter>
THEN PRINT FIELD: <enter>
DEVICE:   Virtual    Right Margin: 80//
```

Figure 14-12: Sort and Print Criteria for the Insurer Fee Schedule Listing

The list will display the following. Note each Fee Schedule entry as the list is reviewed. These schedules may need to be updated with the fees for the newly released codes.

```
3P INSURER LIST                                MAR 31,2020  21:42    PAGE 1
                                      BILLABLE  FEE
INSURER               VISIT TYPE      STATUS    SCHEDULE
------------------------------------------------------------------------------

UNITED HEALTHCARE-RA  INPATIENT       YES       1
```

```
FIRST AMERICAN ADMIN  DENTAL         YES       1
NEVERPAY INSURANCE    OUTPATIENT     BILLAB    1
SNOW BIRD INSURANCE   OUTPATIENT     YES       1
BLACK COMPASS INSURA  OUTPATIENT     YES       1
COLORADO MEDICAID     AMBULATORY SU  YES       2
NEW MEXICO MEDICAID   EPSDT W/O REF  YES       6
MARITIME HEALTH PLAN  OPTOMETRY      YES       6
MISSISSIPPI MEDICAID  DENTAL         YES       7
NEW MEXICO MEDICAID   EPSDT W/REFER  YES       8
                      MULTIPLE VISI  YES       8
BREAST & CERVICAL CA  OUTPATIENT     YES       9
O/P MEDI-CAL  9       OUTPATIENT     YES       10
NEBRASKA MEDICAID     OUTPATIENT     YES       10
PARTNERSHIP HEALTHPL  OUTPATIENT     YES       10
ANTHEM BLUE CROSS     OUTPATIENT     YES       10
PARTNERSHIP HEALTHPL  OUTPATIENT     YES       10
```

Figure 14-13: Displaying the List of Insurers that Contain a Fee Schedule entry

14.2.1.3 Updating the Fee Schedule

3PB→TMTP→FETM→EDFE

The new CPT and HCPCS codes will need to be added to the current fee schedule so that it may be picked up in the Claim Generation process. To add the fees, use the entry from the previous section to determine which fee schedule to update and go to the Fee Schedule Maintenance option located in Third-Party Billing's Table Maintenance menu.

1. Type the **number** of the Fee Schedule to edit at the Select FEE SCHEDULE prompt and press Enter.
2. To edit the Laboratory code of 87635, type **4** at the Select Desired CATEGORY field and press Enter.
    a. When adding the HCPCS codes of U0001 or U0002, type **8** at the Select Desired CATEGORY field and press Enter.
3. At the Select LABORATORY CPT CODE (or HCPCS CODE) prompt, type the **code** and press Enter. The system displays the description for the CPT or HCPCS code.
4. At the Select EFFECTIVE DATE field, type an **effective date** and press Enter. The effective date would more than likely be added as 01/01/2020.
5. The system will ask for a GLOBAL CHARGE amount. Type the **dollar amount** of the test charged and press Enter. At this time, only the GLOBAL charge is needed.
6. Press Enter at the TECHINCAL CHARGE field without typing in a charge.
7. Press Enter at the PROFESSIONAL CHARGE field without typing in a charge.

8. Continue to add charges for remaining CPT or HCPCS codes.

```
Select FEE SCHEDULE: 31// 31      HISTORICAL FEE SCHEDULE (3/11/2018)

----- FEE SCHEDULE CATEGORIES -----


     Select one of the following:

          1         MEDICAL FEES
          2         SURGICAL FEES
          3         RADIOLOGY FEES
          4         LABORATORY FEES
          5         ANESTHESIA FEES
          6         DENTAL FEES
          7         REVENUE CODE
          8         HCPCS FEES
          9         DRUG FEES
          10        CHARGE MASTER

Select Desired CATEGORY: 4  LABORATORY FEES


Select LABORATORY (CPT CODE): 87635    SARS-COV-2 COVID-19 AMP PRB
       INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); SEVERE
ACUTE
       RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-COV-2) (CORONAVIRUS DISEASE
  Are you adding '87635' as a new LABORATORY (CPT CODE)? No// YES  (Yes)
Select EFFECTIVE DATE: 1/1/2020   JAN 01, 2020

GLOBAL CHARGE: 0// 85.00
TECHNICAL CHARGE: 0// <enter>
PROFESSIONAL CHARGE: 0// <enter>
```

Figure 14-14: Adding a Fee to the Fee Schedule

14.3 Addition of a Pending Status Code

Billing updates seem to evolve almost daily. Some locations are still waiting for final billing guidance either from Medicare or their Medicaid state.

The Third-Party Billing Technical Advisory Group (TAG) has approved a New Claims Pending status code. This code will be released in a future patch but if the code is needed to better track claims, the following may be added into RPMS by your RPMS System Administrator via VA FileMan.

Warning: DO NOT ADD ADDITIONAL CODES. Code updates use specific placeholders and additions may be overridden. New manual codes may also be removed with future patch updates.

To add the code, have your RPMS System Administrator perform these steps:

1. Access the VA FileMan Menu.

2. Type **Enter** to Enter or Edit File Entries and press Enter.
3. At INPUT TO WHAT FILE, type **3P CLAIM PENDING STATUS** and press Enter.
4. At the 3P CLAIM PENDING STATUS prompt, type **28** and press Enter. The system asks if you are adding a new entry.
5. Type **YES** and press Enter.
6. Type **Guidelines Pending-Public Health Emergency** at the STATUS field and press Enter. The system confirms the entry number by redisplaying 28//.
7. Press Enter past this field.

Once added, the code will be available for immediate use.

```
Select OPTION: ENTER OR EDIT FILE ENTRIES


INPUT TO WHAT FILE: 3P CLAIM PENDING STATUS


Select 3P CLAIM PENDING STATUS: 28
  Are you adding a new 3P CLAIM PENDING STATUS (the 28TH)? No// YES  (Yes)
   STATUS: Guidelines Pending-Public Health Emergency
   3P CLAIM PENDING STATUS STATUS NUMBER: 28// <enter>
```

Figure 14-15: Adding a New Pending Status for the Claim Editor

15.0 What is Seen in RPMS

15.1 Service Categories

No additional service categories will be added at this time but know the difference between Telemedicine (M) and Telecommunications (T) and which one will be used by providers and coding. Both Service Categories are passed through the coding que and creates claims in Third Party Billing.

15.2 Clinic Stop Codes

A new Clinic Stop code has been distributed. Billers may see this clinic code for claims that generated where the patient is seen for initial COVID-19 testing.

- The clinic code is E8 – Public Health Emergency

Although a new clinic stop code has been added, not all providers may use this code. Scheduling clinics may use other types of clinic stop codes, such as Emergency Medicine, if the patient presented at the Emergency Room. Work with your coding and providers to determine what will be used for reporting in RPMS.

15.3 Coding Que

Telemedicine may be included into the coding que to be reviewed prior to the claim to be generated. Work with your coding department to ensure any new codes that have been added to the coding que has been communicated to the billing department.

15.4 Third Party Billing

Consider adding new visit types to identify the different billing services provided. This would be especially helpful if:

- A new service is being provided and the billing rules are different than billing for other service types.
- Current or future reporting of services provided, billed or if collections on certain services are needed. Visit Types will help to better report on how billing was performed.

15.4.1 UB-04 Point of Origin and Discharge Status Codes

The National Uniform Billing Committee who maintains the UB-04 paper claim form released the following guidance for reporting the point of origin code and discharge status codes:

Point of Origin and Discharge Status Codes for Designated Disaster Alternate Care Sites

For claims involving patients transferred to or originating from designated disaster alternate care sites, the following codes are applicable:

- Point of Origin Code 6 – Transfer from another Health Care Facility (not defined elsewhere in this code list)
- Patient Status Code 69 – Discharged/transferred to a Designated Disaster Alternative Care Site.

Check the NUBC Website for updates at:

https://www.nubc.org/

15.4.1.1 CMS-1500 Claim

The National Uniform Claim Committee has released guidance for use of a Condition Code to report Professional Component claims.

NUCC Approves Use of Condition Code DR for Professional Claims for COVID-19 Related Claims, Effective Immediately

March 24, 2020

The NUCC has approved the use of Condition Code "DR – Disaster Related" effective immediately for COVID-19 related claims on the 1500 Claim Form and in the 837 Professional. The codes available for use for COVID-19 related claims are:

- Condition Code DR – Disaster related; Reported at the claim level in Item Number 10D
- Modifier CR – Catastrophe/disaster related; Reported at the service line level in Item Number 24D

The Centers for Medicare & Medicaid Services (CMS) recently released MLN Matters SE20011 on the use of Condition Code DR and Modifier CR for COVID-19 related Medicare claims. For Medicare, Condition Code DR is reported only in the institutional claim (electronic ASC X12 837I or paper UB-04). The NUCC has approved the use of Condition Code DR in the professional claim (electronic ASC X12 837P or paper 1500) due to the business need by other payers to identify COVID-19 related claims, as it can be used to trigger internal payer steps or processing of claims (e.g., a different routing of the claim for processing).

The complete list of Condition Codes available for use in the professional claim is available on the Condition Codes page under the Code Sets tab.

Check the NUCC Website for updates at: http://nucc.org/.

15.4.2 Visit Location

Some facilities have initialized protocol for screening and treatment of patients suspected and confirmed of having COVID-19. Work with your registration, coding and providers to determine how the facility would be set up. A new visit location may not be immediately set up, as new locations must be requested and approved to get added to RPMS. Note all locations that have special set up protocols in place and make sure all billing staff know how visit data will be stored. Contact the OIT helpdesk for assistance in setting up a billing location.

15.4.3 Laboratory Services

Most recently, the CPT Editorial Panel approved a new Category I Pathology and Laboratory code for novel coronavirus testing. This code is effective March 13, 2020.

- **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.

CPT® 87635 will be a child code under parent code 87471 Infectious agent detection by nucleic acid (DNA or RNA); Bartonella henselae and Bartonella quintana, amplified probe technique in the 2021 CPT® code set.

A special edition CPT® Assistant is publicly available, which provides guidance for using this new code.

Visit the AMA Web site for more information about this new code.

In RPMS, the new laboratory test for COVID-19 may look similar to the following screenshot. Work with your Laboratory Supervisor to confirm the name of any new tests.

```
PCC VISIT DISPLAY          Apr 01, 2020 11:10:42        Page:    3 of    8
+
WHERE SEEN PREFERRED : Outpatient environment
WHERE SEEN SNOMED CT:  33022008
WHERE SEEN PREFERRED : Hospital-based outpatient department
FACE TO FACE SNOMED C: 308335008
FACE TO FACE PREFERRE: Patient encounter procedure
VISIT ID:              2DBGP-PAH


=============== LABs ===============
LAB TEST:              xSARS-CoV-2 RNA, QL
LR ACCESSION NO.:      SO 20 12
ORDER:                 656
SPECIMEN:              NASOPHARYNGEAL MUCUS
SOURCE OF DATA INPUT:  LAB
CURRENT STATUS FLAG:   RESULTED
LOINC CODE:            94531-1
COLLECTION SAMPLE:     SWAB-COVID19
COLLECTION DATE AND T: APR 01, 2020@11:09:56
```

```
ORDERING PROVIDER:      WHITE,LESLIE
CLINIC:                 GENERAL
ORDERING DATE:          APR 01, 2020@11:09:56
RESULT DATE AND TIME:   APR 01, 2020@11:10:14
DATE/TIME ENTERED:      APR 01, 2020@11:10:27
ENTERED BY:             WHITE,LESLIE
DATE/TIME LAST MODIFI:  APR 01, 2020@11:10:27
LAST MODIFIED BY:       WHITE,LESLIE
CPT PTR:                SARS COV2 (QUEST)
CPT - BILLABLE ITEMS:   87635||||90|;U0001||||90|
PROVIDER NARRATIVE:     Well child visit, 13 years
SNOMED CT:              2472299010
```

Figure 15-1: Example of COVID-19 Laboratory Test from the Lab Package in the Visit File

Appendix A: References

- CMS Internet-Only Manual (IOM), Publication 100-02, Benefit Policy Manual, Chapter 15, Section 270
- CMS IOM Publication 100-04, Claims Processing Manual, Chapter 12, Sections 190 – 190.7
- MLN Matters Article, MM10152 - Elimination of the GT Modifier for Telehealth Services
- MLN Matters Article, MM10583 - Revisions to the Telehealth Billing Requirements for Distant Site Services
- MLN Matters Article, MM10883 - New Modifier for Expanding the Use of Telehealth for Individuals with Stroke
- Telehealth Services

Contact Information

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