

Question and Answer COVID Coding: What Ambulance Revenue Cycle Professionals Need to Know Webinar 4/20/2020

HIPAA

Q: We do not have company cell phones. Is it okay to take a picture of the pt. insurance card on a personal cell phone and delete after attaching to the PCR?

A: This has the potential to pose HIPAA risks, because it involves a personal phone with the need to delete the photo. This is not recommended, because PHI will be captured on personal devices. However, be sure to follow your local policies and protocols.

Q: We have heard about the "Ryan White Act" - what is that and how does it relate to the COVID-19 pandemic?

A: The "Ryan White Act" was passed many years ago and was named after a young man who contracted AIDS. The law requires notification of emergency services personnel if they transport a patient to the hospital and the hospital determines the patient has an infectious disease that is covered under the Act. COVID-19 was recently added to the list of diseases that would be covered. [See PWW Workplace Staffing, Safety & Screening FAQ # 13 [here](#)]

CARES Stimulus Payment (General)

Q: Is this incentive payment supposed to be reflected on the Medicare EFT files?

A: The stimulus payment should be directly paid through information available in PECOS and assuming the healthcare provider typically received Medicare funds via EFT. [See PWW Medicare FAQ # 16 [here](#)]

Q: What period of time do we have to spend or use the funds?

A: There is no specific timeframe or deadline in which the stimulus money must be spent.

Q: Is there any amount of time we must use the stimulus money? Will we need to give balance back? Any income tax reduction?

A: There is no timeframe in which the money must or can be spent. As of now, there is no indication that any unused funds need to be returned.

Q: Should the CARES act HHS payment be posted as grant revenue, or transport revenue?

A: Classifying it as “grant revenue” seems to make more sense, as it is not money directly attributable to direct reimbursement from transport (i.e., insurance payment).

Q: We are part of a county government and received our payment last week. Our Behavioral Health department believes that their money is in our deposit. Is this money just for Ambulance and medical healthcare, or is behavioral health included within the CARES Act?

A: Any services billed under the TIN are included in the payment.

Q: The cares act payment, presumably will be considered Taxable income?

A: It is not clear at this point in time. Personal stimulus payments paid to individuals/married couples are not taxable, but it is not clear how these payments to businesses will be classified.

Q: Can reduction in transports be considered for loss of revenues?

A: Yes.

Q: How do we estimate lost sales tax related to COVID-19 to use for the HHS stimulus justification? Is it acceptable to compare to same month last year?

A: That seems reasonable. The difference in the sales tax revenue from last year to this year would be an allowed expense under the stimulus payment.

Q: Is there a way we can we send back a portion of the funds to stay under the \$150,000.00 quarterly reporting requirement.

A: As far as we understand, it is an all or nothing proposition. You either keep all the funds or return all the funds. Remember the \$150,000 threshold includes all federal funding (e.g., PPP loan) and not just stimulus.

Q: Does this cover loss of revenue due to reduction in transportation?

A: Yes, the stimulus payment can help cover reduced volume.

Q: how do we report reduction in transportation? Can we just use prior periods average transport as base?

A: Yes, that is a logical way to try to capture loss in revenue. For example, if you

received \$100,000 reimbursement for April 2019, but considering the pandemic, you only received \$50,000 in reimbursement revenue in April 2020, there would be a net \$50,000 loss in reimbursement revenue.

Q: Do you suggest that we put the HHS funds in a separate checking account?

A: For tracking purposes putting the funds in a separate account (**not** necessarily a separate *checking* account from which all COVID-19 related expenses would then be paid) might help make things a little easier. But there is no requirement that the money go into a separate account, where expenditures would be paid from. But, at least keeping the funds separate and moving them into other accounts as needed to cover expenses and costs can help facilitate the tracking process.

Q: We are looking at spending our stimulus check from HHS for Overtime & PPE – are these legitimate expenses? We also want to confirm we will not have to pay it back, correct?

A: Currently, there is no indication that the stimulus money will have to be repaid. PPE and overtime are the exact kinds of COVID-19 related expenses this stimulus payment was designed to help cover as extraordinary expenses as a result of the pandemic. [See PWW Medicare FAQ # 18 [here](#)]

Q: Can we use the stimulus funds for expenses incurred prior to receiving the stimulus funds?

A: Yes, so long as the expenses related to planning and preparing for the public health emergency related to the COVID-19 pandemic. There are no stipulations or requirements that the stimulus money can only be used for costs incurred after receipt of the money.

Q: Can OT be covered with stimulus money? I thought we could not use it for salaries.

A: The terms and conditions prohibit use of the stimulus money on “exorbitant” salaries (greater than about \$197,000). This is a salary amount that would go to one person, it is not a total of all salaries. Therefore, paying crewmembers for overtime directly caused by the COVID-19 pandemic is permitted under the terms and conditions of the stimulus payment.

Q: Will this be the only stimulus check we are receiving or are we looking at any more payments or assistance?

A: It is possible the government will make additional stimulus payments. We already know that an additional \$70 billion is being made available to cover (among other things) uninsured patients, areas hit hard by the pandemic (e.g., NYC), rural

hospitals and IHS facilities.

Q: We are a public agency and our OT budget has gone over what we anticipated prior to COVID-19 but instead of cutting other budget areas (equip., etc.) to cover is it OK for our department we to use the HHS Payment for that salary is that of concern?

A: Using stimulus money to pay employee salaries and OT costs is absolutely allowed. Paying for additional salary costs (i.e., OT) due to staffing constraints, and increased demand was directly contemplated as part of the reason for making the stimulus payment in the first place. Again, any expenses that are incurred to “prevent, prepare for, and respond to coronavirus” should be covered, and added overtime costs to maintain readiness to respond we believe would be part of those costs.

Q: What if you do not spend all the money the CARES Act sent?

A: We are not aware of any requirement that unused money must be returned. Currently, you are free to retain the unused portion.

Cares Stimulus Payment Terms & Conditions

Q: Would there need to be blocking filters on devices such as smart phones or just blocking filters on the in-network system?

A: The Terms and Conditions document only reference the “computer network.”

Q: Is there a time limit for how long we must abide by the attestation that we sign?

A: As long as the Public Health Emergency is in place.

Q: You said we do not have to do the "CARES Act attestation"? What is the recommendation on this?

A: HHS guidance indicates that if the stimulus money is not returned to the government within 30 days of receipt, retaining the money will be deemed accepting the terms and conditions, regardless of whether the terms and conditions attestation is completed using the on-line portal. Thus, completing the attestation (if you intend to keep the payment) is not actually required. However, not signing the terms and conditions attestation, and keeping the money still means that you have to meet the terms and conditions – in other words, you can't claim ignorance, or try to argue that the terms don't apply because you didn't sign the attestation. The government put you on notice that simply keeping the money means you agree to the terms and conditions.

Q: For the provider CARES money, does the accepting of the in network write offs start at the beginning of the COVID-19 crisis? Or from the date you sign the terms and agreements?

A: Although it is not directly stated anywhere, we believe it makes most sense for the prohibition against balance billing to start as of the date you received the funds.

Q: Is the total cost of PPE or just the increased cost of PPE an allowable expense in your opinion?

A: We believe the total PPE cost could be justified. The funds may be used to “prevent, prepare for, and respond to coronavirus” so we believe that is broad enough to cover all types of PPE costs. Also, on the fact sheet for the CARES Provider Relief Fund, when it comes to eligibility for the funds, it states that HHS broadly views every patient as a possible case of COVID-19. Further, since the funds can be used to cover lost revenues attributable to coronavirus, we believe the intent is allow these funds to be used broadly to cover the increased costs of dealing with the National Health Emergency. However, there may be additional guidance coming from HHS in the future.

Q: I have attempted to access the website listed on page 13 of the handout & found lots of other information on the subject, however is there a central location that lists all the terms & conditions?

A: The terms and conditions can be found [here](#).

Treat No Transport

Q: Since Medicare states they will not cover a "Treat and Release" as it is not a covered benefit. Can the patient then be billed directly? Is this type of patient billing prevented by the Care's Act?

A: As a Medicare non-covered service, the patient can be billed directly for treat and release services provided. This is not prohibited by the terms and conditions of the CARES Act stimulus payment since insurance is not being billed/paying for the service. Some insurers may pay for this service, and of course, if there is some secondary insurer that does pay for treat and release, then that secondary payer could be billed (before billing the patient).

Q: Can you tell me what commercial insurance companies will pay for TNT or treatment in place services?

A: Unfortunately, no. There are literally hundreds of commercial insurers and thousands of plans. This will have to be explored on a payer-by-payer, plan-by-plan, and patient-specific basis.

Patient Balance Billing Under the CARES Stimulus

Q: With Aetna they require the patient to call to get the claim to be paid as in network. The bill we send the patient prompts them to call.

A: As far as we understand, under the stimulus payment, with non-contracted providers, the health insurers are required to process payments as “in-network” and presumably pay the healthcare providers directly, removing this patient obligation to have to call.

Q: How long is the balance billing restriction supposed to last? End of year?

A: Until the end of the Public Health Emergency (“PHE”).

Q: If a patient is possible or confirmed COVID-19 and are uninsured, can we bill them the full amount of their bill?

A: For now, yes, as uninsured patients are not subject to the “balance billing” or “out of pocket expense” limitations connected to the stimulus money. [See PWW Medicare FAQ # 17 [here](#)]

Q: What about billing for the uninsured? On the HHS website there is language regarding a portion of the \$100 billion Provider Relief Fund will be used to reimburse providers at Medicare rates for COVID-19 related treatment of the uninsured

A: This initial stimulus payment relates to balance billing prohibitions after insurance has paid. If the patient is uninsured, there is no insurance payment. However, there is additional \$70 billion of federal funds, which HHS has noted will relate to helping cover healthcare costs of uninsured patients, as well as rural hospitals, HIS facilities, and areas hit hard by COVID-19 (e.g., NYC).

Q: What is the time period that the balance billing for COVID-19 patients is restricted?

A: As far as we understand, this balance billing prohibition will extend for as long as the PHE is in place.

Q: If we choose not to charge the copay to our patients during this crisis time only will we be looked at like a kickback?

A: HHS published some anti-kickback guidance in the wake of COVID-19, but there is nothing definitive about whether “waivers” of ambulance copayments would be construed as AKS problems. Of course, “routine waivers” can pose AKS risks.

Q: Regarding the stimulus payment, wouldn't all responses be considered a potential COVID-19 patient response?

A: Not necessarily. For instance, a patient who falls and has a possible fractured hip and has no other symptoms to indicate possible COVID-19, the patient would be treated as a fall patient, and have no reason to suspect COVID-19.

Q: For balance billing prohibition, if HHS "broadly views every patient as a possible case of COVID19" would you interpret that balance billing is prohibited for all patients?

A: A common sense approach should be taken. If the patient's condition is **not** related at all to COVID-19 (e.g., fall patient, with no signs and symptoms) and there is no reason to suspect COVID-19, then the balance billing prohibition should not apply. Keep in mind that HHS/CMS might presume all patients are possibly COVID relates to signature capture and applying the verbal consent exception. Furthermore, Medicare already does not allow balance billing. The balance billing prohibition applies to commercial insurers for which the HHS/CMS statement treating all patients as possibly COVID-19 should not apply.

Q: When a patient has a co-pay and we do not bill the patient, is that when we would take money from the government allowance?

A: The *co-payment* is expected to be billed and collected by the healthcare provider. Part of the stimulus payment is designed to cover losses from not *balance billing* (difference between charged and paid amount) the patient. You are still expected to collect the co-payment. However, if the patient is unable to afford to pay the co-payment due to losing his or her job as a result of COVID-19, and the co-payment is written off to financial hardship, then yes, this waived co-payment (for financial hardship reasons) can be an expense that can be covered by the stimulus money and reported accordingly.

Q: Would in-network terms then not apply to 911 dispatched EMS since the patient is not ordinarily able to choose to receive an in-network provider.

A: The in-network cost-sharing limitation (i.e. prohibition against balance billing) applies to all COVID-related transports, whether 911 or scheduled.

Uninsured/ Self-pay patients

Q: We have heard that the government will be reimbursing healthcare providers for self-pay patients that have tested positive or suspected COVID-19. My question is: Do you have any idea where we submit these claims?

A: We believe that more information will be forthcoming related to uninsured/self-pay patients. It is possible that money will be paid to cover these lost costs and that

individual claims will not be submitted to a payer. In the interim, we are not aware of anything that would prohibit you from billing the patient directly, as you would normally do for an uninsured patient.

Q: What about private pay patients? As far as the in-network limitations on amounts? or does it ONLY apply to insured patients?

A: Balance-billing prohibitions only applies to insured patients.

Q: Are there any laws regarding uninsured patients during COVID-19?

A: Currently, no. The stimulus payment balance billing limitations only affected insured patients. It is possible that future money will be allocated to help cover possible lost revenue related to uninsured patients.

Q: Is there any change to what we bill a self-pay/private pay patient due to keeping stimulus funds? We can only bill in network amounts if they have insurance but what if there is no insurance?

A: Currently, the stimulus payment prohibits balance billing of possible or actual COVID-19 patients where insurance is involved. HHS stated that additional \$70 billion of stimulus money will become available for healthcare providers to help offset lost revenue when caring for uninsured patients. There is nothing that prevents you from billing uninsured patients under the terms and conditions of accepting the relief funds, if additional money becomes available, it is possible the terms and conditions of that payment would place restrictions and limitations on billing uninsured patients.

Patient Signature exceptions

Q: Are you aware of any provision in NYC that does not require EMS to obtain pt. signatures at all to avoid cross-contamination? This is on every patient – the crews are not getting any signatures at all.

A: We are not aware of any such requirements, but it sounds like the CDC recommendations. However, local or state law limitations related to signature requirements cannot replace Medicare requirements. Regardless, there are additional Medicare options to obtaining alternate signatures, specifically, the “verbal consent.” [See PWW Medicare FAQ # 2 [here](#)]

Q: Can you confirm that HHS has indicated that ALL patients may be considered a possible COVID-19 patient for signature purposes? Can apply modified signature rules to all patients?

A: Yes, HHS did note that “all” patients could be deemed COVID-19, presumably

making the “verbal consent” option available for all patients. However, common sense should be applied. If a patient has no signs and symptoms, and there is no PPE or other isolation/droplet precautions in place, and there is no risk or fear of contamination, then signature capture seems viable.

Q: Will the verbal consent be acceptable for NON-COVID-19 related transports where the patient does NOT want to touch the iPad or Pen for fear of contamination?

A: CMS has only said possible or actual COVID-19 patients. In your example, CMS does not allow the new exception to apply.

Q: For Signatures, HHS broadly stated that all patients are potential COVID-19 does this make the verbal consent exception valid for all patients to create a "contact less" patient care experience?

A: Yes, it is possible to apply the verbal consent exception for all patients for signature purposes. However, common sense could also apply. If the patient is clearly not COVID-19 or suspected COVID, and there are no limitations to obtaining a signature (e.g., fall patient with leg injury), with no PPE or isolations precautions in place, then the patient signature could still be captured.

Alternate Destination & Expanded Modifier Definitions

Q: What about a free-standing vascular clinic – does it qualify as an alternative destination?

A: A free standing vascular clinic could be some alternative destination – likely meeting the “D” modifier.

Q: For alternative destinations, the reg states non-emergency and emergency, does that mean that typical non-emergency transports to MD office can be covered? (Ex. I hurt my leg three days ago and need transport to MD office for evaluation).

A: Theoretically, yes. However, medical necessity must still be met.

Q: Is a physician's office only covered if they are going to that office for COVID-19 related services?

A: No, if it is medically necessary to take the patient to the physician’s office for treatment/services (related to COVID-19 or not), the transport to the physician’s office can be covered.

Q: We have a hospital that is having a difficult time placing COVID-19 positive patients into skilled nursing facilities. They are looking to transport these patients to another one of their hospitals as they have more room there. Can we bill Medicare for the transport and would it be covered?

A: Yes, if the reasons for transport - and medical necessity - are both documented, it should be covered under existing coverage rules.

Q: Do you see any changes that would allow reimbursement for treat and release? Patients do not want to go the hospital unless it is really needed. Protocols have been developed to reduce the number of patient transport.

A: At this point in time, Medicare has continued to state that it will not pay for treatment absent an ambulance transport, but many commercial payers do pay for treat no transport. [See PWW Medicare FAQ # 4 [here](#)]

Q: I just would like to reverify: Tents on a hospital groups running through a hospital would be H modifiers but tents on another site that is not hospital based would be modifier D?

A: Correct.

Q: Would transport of a pt. from their residence to an offsite testing center, such as a parking lot of the health department, be considered an alternative destination that would be covered? If so, would that be a P or D modifier?

A: Yes, that could be a covered “alternate destination” and would likely be fall into the “D” modifier category.

CR/DR and CS Modifier Use

Q: Should we be using the CS modifier on COVID-19 patient's? Either confirmed or possible patient's?

A: The CS modifier is not intended for use on ambulance claims.

Q: Are we able to use the CR modifier and DR condition code in all states at this time?

A: As far as we understand, there are currently no waiver situations in place that would warrant use of “CR” or “DR” modifier for ambulance claims. These secondary modifiers are only required when there is a waiver in place that relates to a relaxed or modified coverage criteria. No such waivers are in place for ambulance. [See PWW Medicare FAQ # 13] However, we are aware of at least one MAC (NGS) that indicated the CR modifier could be appropriate for the new destination modifier descriptions. Although this is not a “waiver,” but instead a change in the regulation, we also understand that MACs still have discretion to request or require CR modifiers be used. [See PWW Medicare FAQ # 13 [here](#)]

Q: When should the "CS" modifier or "CR" modifier be used? And are they used in addition to the original modifier?

A: At this time, neither the CS nor the CR modifier are used for ambulance claims, except for the guidance from NGS regarding use of CR for the expanded ambulance modifier exceptions (as noted above). If used, this CR modifier is a secondary modifier, used after the origin and destination modifier codes.

COVID- specific ICD-10 Codes

Q: If billing staff are not made aware after a patient tests positive for COVID-19 after being transported, do we utilize the symptom codes for our purposes?

A: Using symptom codes (cough, difficulty breathing, etc.) without any COVID-19 related ICD-10 Codes makes most sense where there is no knowledge of confirmed COVID-19 test or whether the patient was, indeed even tested or suspected of having COVID-19.

Q: If we have already billed possible COVID-19 and received payment, but did not use this COVID-19 code - can we resubmit with corrected code?

A: Resubmitting a claim is not recommended. Omitting a COVID-19 ICD-10 Code will likely not be critical.

Q: Are you aware if there are any post COVID-19 diagnosis codes?

A: Not aware of any at this point in time.

Q: Essentially, should we be following up with the hospital to confirm COVID-19 was positive to code correctly as U07.1?

A: No, that is likely not needed, as it adds an extra step. It is not critical that a COVID-19 specific ICD-10 Code be included on the claim.

Q: Can you give an example of ICD codes we can use on our claims when there is documented medical necessity due to COVID-19 cases?

A: Any ICD codes that reference the patient's condition that justifies the use of the ambulance in the first place can continue to be used (in addition to the added COVID-19 specific suggested codes referenced by CDC and HHS. [See Official ICD-10 Reporting Guidelines, [here](#)].

Q: When would we use the code U07.2?

A: This ICD-10 Code would likely not be used for ambulance transports.

Q: For possible COVID-19 patients and applying the balance billing provisions, do you recommend updating claims for positive COVID-19 patients retrospectively? For example: patient does not present with COVID-19 related but later the hospital confirms COVID-19 after the fact, should we refile the claim?

A: We do not think that you need to do anything to correct the claim (or make a refund) that has already been submitted and paid by Medicare. We do not view the ICD-10 Codes related to COVID-19 as being absolutely required or otherwise mandatory. While they do provide a way to track COVID-19 patients using such codes are not required.

Q: Which code comes first? Does the COVID-19 code come first or the J codes?

A: It should not matter, except for any MAC specific requirements on the order of the Codes.

Q: Is there a new diagnosis code for suspected COVID-19 patient after a verbal screening has been administered?

A: We are not aware of any such code.

Prior Authorization for Scheduled Repetitive Transports

Q: Has Palmetto GBA suspended prior authorization?

A: Prior authorization has been placed on “pause.” Prior authorization can still be requested, and if a favorable UTN is obtained, it must be used. Claims will be paid without obtaining a UTN, but transports will be subject to post-payment review. [See PWW Medicare FAQ # 13 [here](#)]

Physician/ Non-Physician Certification Statements

Q: Was there any discussion with CMS about relaxing requirements for the PCS form due to isolation as they did with the CMS forms? We are having a hard time getting these forms from the flight crews we take to our hospital when they have a COVID-19 pt. and they are not notifying us ahead so we don't get a fax and the crews hesitate to get them at the time of transport now because it takes so long for the flight crew to doff isolation.

A: We are not aware of any CMS guidance related to PCS requirements.

Medical Necessity

Q: Do we have to provide proof of positive COVID-19 to bill Medicare?

A: No. As long as the service meet medical necessity ambulance transport can be paid by Medicare – there is no requirement that the patient must be positive for COVID-19 to make the transport meet medical necessity.

Q: What if hospital order a transport to another Hospital and the medical necessity is not met? Are we to refuse the transport or inform the patient that the insurance will not cover?

A: You can still perform a transport; it just not be billable to Medicare. You can advise the patient that medical necessity is not met, and that the patient might be financially responsible. You generally have the right to refuse a non-emergency transport and choosing to do so is a business decision.

Q: Is infection disease control a medical necessity for BLS?

A: It can be, provided it is well-documented by the crew (i.e., need for PPE, masks, isolation, etc.) [See PWW Medicare FAQ # 3 [here](#)]

Q: When a person needs to be transported from the hospital to their nursing home and the family cannot bring them home due to families not allowed to lock down of nursing home? Is this a medical necessity for use of ambulance?

A: Simple unavailability of other sources of transport is likely not enough to meet medical necessity. BUT, if the patient meets medical necessity for ambulance (e.g., isolation, PPE, etc.) than medical necessity could be met.

Q: Does an ambulatory dialysis patient who is COVID-19 positive with signs and symptoms meet medical necessity for ambulance (there is a PCS signed by a physician)?

A: If the patient requires isolation precautions and PPE which would be unavailable in alternate forms of transport, then medical necessity could be defensible. We believe there is a strong argument that it is “unsafe” to transport the patient by means other than an ambulance in this situation, due to the high risk of contagion. It all depends on the quality and completeness of the crew documentation. Simply noting “COVID” will be insufficient to justify medical necessity – documentation of the clinical indications and those positive signs and symptoms is essential.

Miscellaneous

Q: Would it be possible to subcontract with another provider at an hourly rate and bill Medicare for the charge through our Medicare number?

A: No, this would misrepresent things to Medicare. If one ambulance service performed the service, a different ambulance service cannot bill that service under its own ambulance service provider number.

Q: Are there any GEMT issues we should be aware of?

A: We are not aware of any correlation between GEMT and other issues going on concerning COVID-19 (e.g., stimulus payments, PPP loans, etc.).

Q: Will a hospital to hospital transport be covered if the sending hospital is being specifically used just for COVID-19 positive patients and sends an ER patient that is non-COVID-19 to another hospital for admit? Will that be considered a level of care not available at the sending hospital?

A: Yes, that sounds like a definite possibility for purposes of meeting reasonableness.

Q: What would be time frame to submit the COVID-19 claims to Medicare? What happens when a COVID-19 claims is denied, what is the appeal procedure?

A: COVID-19 claims would be submitted to Medicare as usual – there are no special timeframes or extension to the one-year filing deadline. If the claim is denied, the same appeal process would apply, but there are some extensions to the appeal deadlines in effect in light of the COVID-19 pandemic.

Q: If a pt. calls and says they do not have to pay their bill because of COVID-19 are they responsible to provide documentation?

A: We recommend applying your existing financial hardship policy/protocol for any patient who claims inability to pay.

Q: Are there any issues with discounting the charges for an uninsured patient's before sending them the first bill?

A: You should bill uninsured patients as you would any other payer (i.e., consistent with policies/protocols and/or charging the patient at your full charge up front). Then, if the patient is unable to pay or claims financial hardship, exceptions can be made based on an established hardship policy. But it is best to start the charge at the standard charge, instead of offering discounts from the outset, and without assessing the patient's ability to pay.