Critical Care Documentation and Billing Update: COVID-19 Pandemic

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Introduction

The COVID-19 pandemic has presented a unique set of challenges. These challenges have been tempered to some extent by provisions made by the American Medical Association and Centers for Medicare and Medicaid Services (CMS) to assist with the billing and documentation burden. Their goals are to create temporary hospitals, facilitate out-of-state hiring of providers, increase access to telemedicine, increase availability of testing, and minimize paperwork. We discuss some of the key points about appropriateness of documentation and billing based on guidance provided by these organizations.

ICD-10-CM Coding for COVID-19

For a confirmed diagnosis, assign code U07.1, COVID-19. If the provider documents "suspected," "possible," "probable," or "inconclusive" COVID- 19, do not assign code U07.1; instead code by symptom or other illness.

When COVID-19 meets the definition of principal diagnosis, code U07.1, COVID-19, should be sequenced first, followed by the appropriate codes for associated illnesses such as acute respiratory illness, renal failure, etc., except in the case of pregnancy.

For acute respiratory illness with COVID-19, use U07.1 followed by the appropriate code depending on the presentation, such as:

- J12.89: other viral pneumonia
- J80: acute respiratory distress syndrome (ARDS)
- J22: unspecified acute lower respiratory infection

For pregnant patients, the chapter 15 diagnosis codes (O00-O9A) take sequencing priority. In these cases, use the principal diagnosis code O98.5-, other viral diseases complicating pregnancy, followed by U07.1.

For example, a patient with COVID-19, ARDS, and acute renal failure would be coded as U07.1 (COVID-19), J80 (ARDS), and N17.9 (acute renal failure).

For patients presenting with any signs or symptoms associated with COVID-19 (such as fever) but for whom a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms, such as:

- R05 for cough
- R06.02 for shortness of breath
- R50.9 for fever, unspecified

For a patient exposed but without a COVID-19 laboratory diagnosis, use Z20.828-, contact with and (suspected) exposure to other viral communicable diseases.

To learn more about appropriate use of ICD-10 codes, refer to https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf.

ICU Services Under Revised CMS Policy

CMS has incorporated several key temporary regulatory waivers to help providers deal with the COVID-19 pandemic. These are effective immediately.

Most relevant to critical care practitioners are the following codes:

- Emergency department visits, levels 1-5 (CPT codes 99281-99285)
- Critical care services (CPT codes 99291-99292)
- Initial and continuing intensive care services (CPT codes 99477- 99480)
- Initial hospital care and hospital discharge day management (CPT codes 99221-99223 and 99238-99239)
- Inpatient neonatal and pediatric critical care, initial and subsequent (CPT codes 99468- 99473 and 99475-99476)
- Remote patient monitoring (CPT codes 99091, 99457-99458, 99473-99474, 99493-99494)
- Critical care consult codes more than once per day (CPT codes G0508-G0509).

Extending the reach of physicians is being accomplished in other ways as well. Physicians can now supervise trainees virtually for nonsurgical therapies. CMS is temporarily waiving 482.12(c)(1-2) and (4) so that physician assistants and nurse practitioners can independently care for Medicare and Medicaid patients.

Billing for procedures remains unchanged and requires appending appropriate ICD-10 diagnosis code and modifiers.

CMS Telemedicine Rules During the COVID-19 Public Health Emergency

Telemedicine is a great approach for the COVID-19 pandemic because it allows for patient care while practicing social distancing. Telemedicine is not new but providing the breadth and diversity of healthcare services that COVID-19 demands creates new challenges, including documentation and reimbursement.

Under these new guidelines, providers can care for established or even new patients regardless of geographic location. Services include emergency department, 24-hour observation stays, hospital admission, and daily care, including ICU, nursing facility visits, home visits, care planning for cognitive impairment, psychological care, physical and occupational therapy, speech therapy, and licensed social work.

CMS can provide accelerated or advance payments during the pandemic to a Medicare provider if the provider requests the appropriate Medicare Administrative Contractor and meets the required qualifications. Details on this process can be found here: https://www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf.

A complete list of telemedicine services is available at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

The requirement for specific state licenses to practice telemedicine within that state has temporarily been waived, with some limitations. Provider must have a state license in the United States, be enrolled in Medicare program, be providing telemedicine to a state in a pandemic emergency, and not be prohibited from practicing medicine in the state.

CMS has changed restrictions on making referrals for healthcare services to other entities which with the physician may have a financial relationship. Physician-owned hospitals can temporarily increase their bed capacity and not be in violation of Stark Law.

COVID-19-Specific Miscellaneous Key points

- Any qualified provider can bill for critical care services. This is not limited to critical care practitioners only.
- Critical care services are not location specific and can be provided to the patient in any designated in-hospital location.
- Time rules for critical care services still apply, along with appropriate use of modifiers for procedures that are not bundled.

In conclusion, while new temporary standards and definitions have been created to guide documentation and billing during the COVID-19 emergency, we urge readers to seek guidance from their quality and compliance teams to ensure appropriate application. Also, due to the dynamic nature of this guidance, every effort should be made to stay current using the sources below.

Sources

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